PART I

Counseling for Adjustment Disorders and Life Stress

1 PREVALENCE OF ADULT DISORDERS

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The notion of prevalence occurs in medical and psychological research but the methods used to estimate prevalence yield far more general results than many clinicians may suppose. Prevalence is determined through statistical probability and, as the mathematician Morris Kline (1972) noted, statistics are first and foremost a confession of ignorance. The statistics with which mental health professionals estimate the prevalence of mental/emotional disorders are drawn from epidemiological research. Epidemiological research is the study of the incidence, distribution, and consequences of particular problems in one or more specified populations as well as factors that affect distribution of the problems in question (Barlow & Durand, 1999; U.S. Department of Health, Education, and Welfare, 1978).

Gathering accurate statistics on mental and emotional disorders has always been a challenging task. The Association of Medical Superintendents of American Institutions for the Insane (later renamed the American Psychiatric Association—APA) first initiated this task in 1917. The responsibility for gathering statistics was shifted to the Biometrics branch of the National Institute of Mental Health (NIMH) in 1949 (American Psychiatric Association, 2000a). The APA relies heavily on the epidemiological research of others for the prevalence estimates found in the various Diagnostic and Statistical Manuals. Epidemiologic research may be carried out by one or two persons or in massive projects like the NIMH Epidemiologic Catchment Area Program (Eaton & Kessler, 1985).

DuPont, DuPont, and Spencer (1999) stated that the epidemiology of mental/emotional disorders was really begun in the 1970s in the Epidemiologic Catchment Area (ECA) study that used large samples from five communities in the United States. From this data, generalizations were extrapolated to the U.S. population in general producing the first national estimates for specific disorders. They noted that the first "truly national sample" was the National Comorbidity Study (NCS) conducted between 1990 and 1992 that used *DSM-III-R* criteria.

Since statistics are first and foremost a confession of ignorance, prevalence data based on statistics are always works in progress to be understood as "best guesses" given available methodologies. Several problems challenge researchers to make accurate estimates regarding the prevalence of a particular disorder. First, there is a significant time lag between the refinement of an edition of the *DSM,* and the gathering and analysis of data. For example, studies are still being published estimating prevalence based on *DSM-III-R*

criteria (Kessler et al., 1997) that was replaced in 1994 by *DSM-IV* (which was replaced in 2000 by *DSM-IV-TR*). When the *DSM* is updated, additional disorders may be added and criteria or descriptors associated with a disorder may change. For example the *DSM-IV* (APA, 1994) added Bipolar II Disorder to describe individuals who suffered from major depressive episodes and a low-grade mania (hypomania) but not mania proper. *DSM-IV-TR* (APA, 2000b) went on to make changes in the narrative section describing the relationship between Bipolar I Disorder and Bipolar II disorder.

A second problem associated with estimating prevalence has to do with the methods used. As any researcher knows, some research methods are better than others. There is a paucity of research comparing various methods or data gathering instruments (Boyle et al., 1997; Regier, 2000) and reported prevalence rates may vary study by study (Regier et al., 1998). Methods of epidemiological research on mental disorders have varied over time. Kohn, Dohrenwend, and Mirotznik (1998) stated that there have been three generations of evolving, large-scale epidemiological research using two strategies. Each generation has used different psychiatric nosologies and data collection tools. The first generation relied primarily on institutional records and key informants but no real standardized procedures for data collection. The second generation utilized structured interviews in the community by nonclinical interviewers that were subsequently rated by a psychiatrist. The third generation (starting around 1980) used clinician and trained nonclinician interviewers in the community to obtain information necessary to determine the presence of mental disorders as categorized in the *DSM.* This present generation utilizes explicit diagnostic criteria as well as structured clinical interview schedules (Dohrenwend, 1998; Eaton & Kessler, 1985; Kohn et al., 1998). Currently, all epidemiologic approaches are based on personal interviews and there is still controversy over the accuracy of the interview method particularly over whether it is appropriate to use lay-interviewers (Dohrenwend, 1998). Dohenwend noted ". . . classification systems in psychiatry have been and will continue to be tentative as long as disorders are grouped on the basis of signs and symptoms elicited in interviews" (pp. 146–147).

Perhaps the most substantial problem with epidemiological data is summarized by Blazer and Kaplar (2000) who stated that a central conflict is whether or not symptoms reported by community residents in structured interviews are clinically significant or not. On one side of the debate, Regier (2000) noted that the conflict could be resolved with better research methods that would allow a diagnosis to be made from the results of a structured clinical interview. On the other side, Spitzer (1998) and Frances (1998) have asserted that data from epidemiological studies cannot replace clinical judgment. Blazer and Kaplar (2000) contended that the conflict could not be resolved because the methodologies of both sides are plagued with measurement error.

In this chapter, we briefly review the prevalence of the most common adult disorders. We have organized the chapter so the disorders are presented in the same order as they appear in the *DSM.* Disorders usually first diagnosed in infancy, childhood, or adolescence can be found in Chapter 20. Mental disorders due to or related to general medical conditions are omitted as are many subtypes of larger syndromes (e.g., dementia due to head trauma). There are numerous disorders for which there are no clear epidemiological data (e.g., Pain Disorder, Factitious Disorder, and all of the Dissociative Disorders). These have also been omitted from this chapter.

Some disorders are discussed in terms of point prevalence, some in terms of lifetime prevalence, and some in terms of both. Point prevalence refers to the estimated proportion of people in the population thought to suffer from the disorder at any given time. Lifetime prevalence is an estimate at a given time of all individuals who have ever suffered from the disorder. Incidence refers to the rate of new cases in a specified period of time (usually annually) (LaBruzza, 1997). Which of these types of prevalence or incidence data should be cited depends on the availability of data. Unless otherwise noted, estimates of prevalence are taken from *DSM-IV-TR* (APA, 2000b).

Attention Deficit Hyperactivity Disorder (ADHD). Although there is limited prevalence data on ADHD in adults, it is estimated that of the 3% to 9% of children suffering from the disorder, the disorder will persist into adulthood for 10% to 50% of these afflicted children (Levin & Donaldson, 1999). Barkely (1998) has noted that the *DSM* criteria sets are developmentally insensitive so he believes that the percentages of afflicted children who will continue to suffer from the disorder in adulthood range from 3% to 68%. Barkley's point is that patients may outgrow the diagnosis but not the disorder.

Delirium. The point prevalence is estimated at 0.4% in adults 18-years-old and older. The point prevalence for adults 55 and older is estimated at 1.1%. In hospitalized patients with medical illness, the point prevalence ranges from 10% to 30% and up to 60% of nursing home residents age 75 and older may be delirious at any given time.

Dementia. Dementia may have one of 75 or more etiologies. 1% to 5% of these are reversible while approximately 95% are progressive (Alzheimer's type being the most common progressive dementia) (Nussbaum, 1998). Prevalence figures vary study by study and range from 1.4% to 1.6% for individuals between the ages of 65 to 69. The prevalence increases with age and rises to 16% to 25% for individuals over 85 years of age.

Dementia of the Alzheimer's Type (ALZ). Like progressive dementias in general, ALZ incidence increases with the age of the cohort under study. At age 65, the prevalence is 0.6% in males and 0.8% in females. Respectively, these increase to 11% and 14% at age 85 and 21% and 25% at age 90.

Substance Use Disorders (SUDs). It is difficult to make estimates of substance use disorders with adults particularly when the use of numerous licit and illicit substances may be common and even culturally reinforced. In addition, the very notion of substance abuse as a syndrome meriting inclusion in *DSM* is still debated (Helzer, 1994). Mirin et al. (2000) estimated that approximately 15% of regular users of any substance will become psychologically dependent on that substance, that is, they come to believe they are unable to function without it. Data on physical dependence varies depending on the substance. It should be noted that although each subcategory below bears the generic label for disorders related to a substance (e.g., Alcohol-Related Disorders), for most subcategories, all we have are estimates of use which give us no clue as to how many users would meet the criteria for abuse or dependence.

Alcohol Dependence (AD). Estimates of prevalence vary markedly across studies for both alcohol abuse and dependence. Using *DSM-III-R* and *DSM-IV* criteria, it is estimated that the lifetime risk for alcohol dependence in the mid-1990s was approximately 15% with the point prevalence being 5%. According to the ECA survey, 37% of people with an alcohol disorder had another comorbid mental/emotional disorder (Gallant, 1994).

Amphetamine-Induced Disorders. The *DSM-IV-TR* notes that the patterns of amphetamine use differ geographically and over time in the general population. More recent estimates report approximately 5% of adults ever using stimulant drugs to get "high" with 1% reporting such activities in the prior year. A national epidemiological study in the early 1990s reported a lifetime prevalence of 1.5%. Although these estimates are thought to address amphetamines proper and amphetamine-like substances, they probably do not address the full chemical diversity of the amphetamine molecule and the chemical variations that are produced and sold illegally. For example, 3,4-methylenedioxymethamphetamine ("Ecstasy") is technically an amphetamine derivative but is classed as a hallucinogen.

Caffeine-Related Disorders. It is estimated that 80% to 85% of adults consume caffeine within any given year and larger numbers of youth are thought to be using caffeine products. The prevalence of caffeine-related disorders is unknown.

Cannabis-Related Disorders. Marijuana is estimated to be the most frequently abused illicit psychoactive drug in the United States. Because of the legal issues involved and the variable patterns of use, it is difficult to estimate the number of users meeting the criteria for abuse or dependence. A 1992 survey

estimated that lifetime rates of cannabis dependence or use are approximately 5%. Use has been estimated for adults 18 to 29 who ever used (26%), to used in the last 30 days for high school seniors (14%), to daily use in high school seniors and young adults (3.7% of adult males and 1.6% of adult females (Millman & Beeder, 1994).

Cocaine-Related Disorders. The patterns of cocaine use are believed to fluctuate with the times. A 1996 national survey estimated that 10% of the population had ever used cocaine and 2% had used it in the previous year. Crack use was less prevalent with 2% of the population estimated to have ever used and 0.6% using in the last year.

Hallucinogen-Related Disorders. The estimation of hallucinogen-related disorders is complicated by the disagreement over which substances are hallucinogens proper. The current category includes 3,4-methylenedioxymethamphetamine which is chemically an amphetamine derivative and experientially an empathogen rather than a hallucinogen. Until current disagreements regarding classification are resolved, it is unlikely that we will have accurate prevalence estimates. According to the 1996 survey used by the writers of the *DSM-IV-TR,* 10% of the population age 10 and older is estimated to have ever used a hallucinogen.

Inhalent-Related Disorders. It is difficult to estimate the prevalence of these because it is thought their use might be underrepresented in surveys. The current estimates from the 1996 survey indicate that around 6% of the U.S. population is thought to have ever used an inhalant with 1% reporting use in the past year.

Nicotine-Related Disorders. As of the 1996 data, 72% of the U.S. population is thought to have ever used cigarettes with 32% using in the past year. Lifetime prevalence is highest for those 35 and older (78%) but use in the prior year was highest in the 18 to 25 year old age group (45%). It is estimated that 80% to 90% of regular smokers have nicotine dependence, which equals an estimate of 25% of Americans. Greater decreases in smoking are seen for Caucasians than African Americans or Hispanics. Increases in smoking have been reported since the mid-1990s for women with less than a high school education. It is estimated that 17% of Americans have ever used smokeless tobacco products but there are no estimates for dependence in this group.

Opioid-Related Disorders. In 1996, 4% of men and 6% of women were estimated to have ever used an analgesic drug in a manner other than that for which it was prescribed (2% in the past year). The 18- to 25-year-old cohort had the highest prevalence of ever using an analgesic in this manner (9%). The lifetime prevalence for heroin use is around 1%.

Phencyclidine-Related Disorders. Data from 1996 reported that 3% of Americans ages 12 and older have ever used phencyclidine (PCP) with the highest lifetime prevalence (4%) being reported in the 26 to 34 year old age group. Phencyclidine is thought to account for about 3% of substance-related deaths.

Sedative, Hypnotic, or Anxiolytic-Related Disorders. More than 15% of Americans use these medications in any given year. Most take as directed without any misuse. 1996 data estimate that 6% of Americans have ever taken these drugs illicitly. The age group with the highest estimated illicit use was 26- to 34-year-olds (3% using "sedatives" and 6% using "tranquilizers").

Schizophrenia. Schizophrenia is observed across cultures, worldwide. The prevalence among adults is thought to be between 1% and 1.5% of adults.

Delusional Disorder. This disorder is thought to be uncommon in outpatient clinical settings. It is estimated that the disorder is prevalent in 1% to 2% of inpatient mental health facilities.

Major Depressive Disorder (MDD). The lifetime prevalence of MDD varies between 10% to 25% for females and 5% to 12% for males. The point prevalence varies from 5% to 9% for females and 2% to 3% for males.

Dysthymic Disorder (DD). Estimates vary regarding DD. Lifetime prevalence is estimated to be 6% while the point prevalence is thought to be around 3%. Keller and Russell (1996) have noted that chronic depression is

generally common in community samples with 2.7% to 4.3% being diagnosed with DD.

Bipolar I Disorder. The estimated lifetime prevalence of Bipolar I disorder in community samples fluctuates between 0.4% to 1.6%.

Bipolar II Disorder. There is scant data on Bipolar II disorder partially because of its newness (first listed in *DSM-IV*) and because of difficulties making the diagnosis accurately. Current estimates of lifetime prevalence are 0.5% of the population.

Cyclothymic Disorder. Studies estimate the prevalence to be between 0.4% and 1% of the population. The prevalence in mood disorders clinics is higher, between 3% and 5%.

Panic Disorder (with or without Agoraphobia). Most studies report rates between 1% and 2% although some estimate as high as 3.5% of the general population. The one-year prevalence rates range between 0.5% and 1.5% of the population.

Specific Phobia. Phobias are common in the general population although they rarely reach the level of distress or impairment necessary to qualify as a mental and emotional disorder. Estimated prevalence varies depending on the threshold used to determine distress and impairment. In community samples prevalence estimates range between 4% and 8.8%. Lifetime prevalence estimates range between 7.2% and 11.3%.

Social Phobia (SB). The estimated lifetime prevalence is 3% to 13%. The 6-month prevalence is estimated to be 0.9% to 1.7% for males and 1.5% to 2.6% for females (Myers et al., 1984). In the general population most people with SB have a fear of public speaking.

Obsessive-Compulsive Disorder (OCD). Lifetime prevalence is estimated at 2.5% and 1-year prevalence between 0.5% to 2.1%. The average age of onset ranges from early adolescence to the mid-twenties.

Posttraumatic Stress Disorder (PTSD). The lifetime prevalence for PTSD ranges from 1% to 14% and the variability is related to the methodology used and the population sampled. Studies of at-risk individuals (e.g., combat veterans, victims of volcanic eruption or criminal violence) yield even broader prevalence rates ranging from 3% to 58%.

Acute Stress Disorder. The prevalence of Acute Stress Disorder in the general population is not known. However, for victims of severe trauma, it is estimated to be between 14% and 33%.

Generalized Anxiety Disorder (GAD). The point prevalence for GAD has been estimated at 2% for females and 4% for males (Wittchen, Zhao, Kessler, & Eaton, 1994) Lifetime prevalence is estimated at 5%.

Somatization Disorder. Studies have reported widely variable prevalence rates ranging from 0.2% to 2% for women and less than 0.2% for men.

Conversion Disorder. Reported rates for Conversion Disorder vary widely and are not well defined. They range from 11 people out of every 100,000 to 500 people in every 100,000.

Hypochondriasis. The incidence of hypochondriasis is estimated to be 2% to 7% in general medical practice. The prevalence for the general population is estimated at 1% to 5%.

Sexual Disorders. Scant epidemiological data exists on the sexual disorders. The *DSM-IV-TR* relies on one comprehensive study that summarizes sexual complaints that may be related to particular disorders. There is no way of knowing if the complaints would reach the levels of distress and impairment necessary to actually make the diagnosis.

Hypoactive Sexual Desire Disorder. The one comprehensive study to date has estimated that as many as 33% of women may suffer from complaints in this category at any given time. Clearly this high number may include complaints related to the context of the person's life that may never qualify as the disorder proper.

Arousal Problems. The problems in this category could be prominent in Female Sexual Arousal Disorder and Male Erectile Disorder. It is estimated that at any given time, 20% of females may have complaints related to arousal problems and 10% of males would have complaints related to erectile dysfunction.

Orgasm-Related Problems. The problems in this category could be related to Female Orgasmic

Disorder, Male Orgasmic Disorder, and Premature Ejaculation. At any given time, 25% of females and 10% of males are estimated to have complaints related to orgasms.

Dyspareunia. Problems that may fit this category given sufficient impairment and distress are estimated to be experienced by 3% of males and 15% of females.

Anorexia Nervosa. Lifetime prevalence among females is estimated to be 0.5% of the population although there are many more women who are suffering from related symptoms that are sub-threshold for the disorder. Prevalence in males is thought to be ⅒ that of women.

Bulimia Nervosa. The general prevalence is estimated to be 1% to 3% among adolescent and young adult females. Male occurrence is thought to be ⅒ of that.

Primary Insomnia. Primary Insomnia is thought to afflict 1% to 10% of the general population and up to 25% of elderly people.

Narcolepsy. Studies estimate that between 0.02% and 0.16% of the population is afflicted with Narcolepsy.

Breathing-Related Sleep Disorders. The most common of these is Obstructive Sleep Apnea Syndrome which is thought to afflict between 1% and 10% of the population.

Sleepwalking Disorder. The prevalence of sleepwalking disorder is thought to be in the range of 1% to 5% while incidents of sleepwalking (not the disorder per se) are more common for up to 7% of adults.

Pathological Gambling. This is the only disorder in the category of Impulse-Control Disorders Not Elsewhere Classified with any community estimates. For adults, the estimated prevalence is 0.4% to 3.4%.

Adjustment Disorders (AD). It is estimated that between 10% and 30% of clients in mental health outpatient settings suffer from adjustment disorders of some type. One would suspect that the prevalence in the general population would be higher although there are no epidemiological studies to support that hypothesis.

Personality Disorders. The personality disorders in the *DSM* are the least validated in the manual. One problem is great comorbidity where 50% of people meeting the criteria for one personality disorder also meet the criteria for at least one more. Tyrer (1995) stated that "the degree of overlap between and among the different personality disorders is far too great, and the specious use of the term "comorbidity" hides diagnostic confusion" (p. 29). He concluded that even if the categories were more valid, there is no way to classify a person meeting the criteria for more than one personality disorder. Without going further into the debate about the validity of these categories, suffice it to say that one should be mindful of the debate while reading current prevalence data. Disorders for which there is no prevalence data (e.g., Schizoid Personality Disorder) have been omitted from this chapter.

Paranoid Personality Disorder. Estimated to be present in between 0.5% and 2.5% of the general population.

Schizotypal Personality Disorder. Estimated to be present in 3% of the general population.

Antisocial Personality Disorder. Estimated to be present in 3% of males and 1% of females in the general population.

Borderline Personality Disorder. Estimated to be present in 2% of the general population.

Histrionic Personality Disorder. Limited data allow for estimates of about 2% to 3% of the general population.

Narcissistic Personality Disorder. Estimated to exist in less than 1% of the general population.

Avoidant Personality Disorder. Estimated to exist in between 0.5% and 1% of the general population.

Obsessive-Compulsive Personality Disorder. Estimated to be present in approximately 1% of the general population.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000a). *DSM: A brief historical note* [Online]. Available: www.psych.org/htdocs/pnews/98-04-03/hx.html.

American Psychiatric Association. (2000b). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Barkley, R.A. (1998). Attention deficit hyperactivity disorder: Long-term course, adult outcome, and comorbid disorder. In *NIH consensus development conference: Diagnosis and treatment of attention deficit disorder* (pp. 57–59). Bethesda, MD: National Institutes of Health.

Barlow, D.A., & Durand, V.M. (1999). *Abnormal psychology* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Blazer, D.G., & Kaplar, B.H. (2000). Controversies in community-based psychiatric epidemiology: Let the data speak for themselves. *Archives of General Psychiatry, 57,* 227.

Boyle, M.H., Offord, D.R., Racine, Y.A., Szatmari, P., Sanford, M., & Fleming, J.E. (1997). Adequacy of interviews vs. checklists for classifying childhood psychiatric disorders based on parents' reports. *Archives of General Psychiatry, 54,* 793–799.

Dohrenwend, B.P. (1998). A psychosocial perspective on the past and future of psychiatric epidemiology. *American Journal of Epidemiology, 147,* 222–231.

DuPont, R.L., DuPont, C.M., & Spencer, E. (1999). Generalized anxiety disorder: A clinician's guide to "the worry disease." *Directions in Psychiatry, 19,* 133–144.

Eaton, W.W., & Kessler, L.G. (1985). *Epidemiologic field methods in psychiatry: The NIMH epidemiologic catchment area program.* Orlando, FL: Academic Press.

Frances, A. (1998). Problems in defining clinical significance in epidemiologic studies. *Archive of General Psychiatry, 55,* 119.

Gallant, D. (1994). Alcohol. In M. Galanter & H.D. Kleber (Eds.), *Textbook of substance abuse treatment* (pp. 67–90). Washington, DC: American Psychiatric Press.

Helzer, J.E. (1994). Psychoactive substance abuse and its relation to dependence. In T.A. Widiger, A.J. Frances, H.A. Pincus, R. Ross, M.B. First, & W. Wakefield Davis (Eds.), *DSM-IV sourcebook: Volume 1* (pp. 21–33). Washington, DC: American Psychiatric Press.

Keller, M.B., & Russell, C.W. (1996). Dysthymia. In T.A. Widiger, A.J. Frances, H.A. Pincus, R. Ross, M.B. First, & W. Wakefield Davis (Eds.), *DSM-IV sourcebook: Volume 2* (pp. 21–35). Washington, DC: American Psychiatric Press.

Kessler, R.C., Crum, R.M., Warner, L.A., Nelson, C.B., Schulenberg, J., & Anthony, J.C. (1987). Lifetime co-occurrence of *DSM-III-R* alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. *Archives of General Psychiatry, 54,* 313–318.

Kline, M. (1972). *Mathematical thought from ancient to modern times.* New York: Oxford University Press.

Kohn, R., Dohrenwend, B.P., & Mirotznik, J. (1998). Epidemiological findings on selected psychiatric disorders in the general population. In B.P. Dohrenwend (Ed.), *Adversity, stress and psychopathology* (pp. 235–284). New York: Oxford University Press.

LaBruzza, A.L. (1997). *Using DSM-IV: A clinician's guide to psychiatric diagnosis.* Northvale, NJ: Aronson.

Levin, F.R., & Donaldson, P.L. (1999). Diagnosis and treatment of ADHD in drug dependent adults. *Directions in Psychiatry, 19,* 251–268.

Millman, R.B., & Beeder, A.B. (1994). Cannabis. In M. Galanter & H.D. Kleber (Eds.), *Textbook of substance abuse treatment* (pp. 91–100). Washington, DC: American Psychiatric Press.

Mirin, S. L., Bukstein, O., Isbell, P.G., Kleber, H., Schottenfeld, R.S., Weiss, R.D., & Yandrow, V.W. (2000). Practice guideline for the treatment of patients with substance use disorders: Alcohol, cocaine, opiods. In *American Psychiatric Association Practice guidelines for the treatment of psychiatric disorders* (pp. 139–238). Washington, DC: Author.

Myers, J.L., Weissman, M.M., Tischler, G.L., Holzer, C.E., Leaf, P.J., Orvaschel, H., Anthony, J.D., Boyd, J.H., Burke, J.D., Krammer, M., & Stolzman, R. (1984). Six month prevalence of psychiatric disorders in three communities. *Archives of General Psychiatry, 41,* 939–957.

Nussbaum, P.D. (1998, October). *Aging of the brain, aging of the mind.* Unpublished lecture delivered in Akron, OH.

Reiger, D.A. (2000). Community diagnosis counts. *Archives of General Psychiatry, 57,* 223.

Reiger, D.A., Kaelber, C.T., Rae, D.S., Farmer, M.E., Knauper, B., Kessler, R.C., & Norquist, G.S. (1998). Limitations of diagnostic criteria and assessment instruments for mental disorders: Implications for research and policy. *Archives of General Psychiatry, 55,* 109–115.

Spitzer, R. (1998). Diagnosis and need for treatment are not the same. *Archives of General Psychiatry, 55,* 120.

Tyrer, P. (1995). Are personality disorders well classified in *DSM-IV*? In W.J. Livesley (Ed.),

The DSM-IV personality disorders (pp. 29–44). New York: Guilford Press.

U.S. Department of Health, Education, and Welfare. (1978). *Epidemiology, health systems research, and statistics/data systems: Report of an ADAMHA workgroup.* Washington, DC: Author.

Wittchen, H-U., Zhao, S., Kessler, R.C., & Eaton, W. (1994). *DSM-III-R* generalized anxiety disorder in national comorbidity survey. *Archives of General Psychiatry, 51,* 355–364.

2 COUNSELING CLIENTS WITH UNDERLYING MEDICAL PROBLEMS

Christiane Brems

In recent years, studies have documented a strong link between medicine and psychology, as many clients with mental health concerns actually suffer from medical illness and vice versa. Tomb (1995) found that 50% to 80% of patients treated in medical clinics actually had a diagnosable psychiatric disorder; 60% of patients treated by general medical practitioners actually needed mental health care; and 50% of patients in psychiatric clinics had undiagnosed medical illnesses. Wickramasekera, Davies, and Davies (1996) showed that over half of patient visits to primary care physicians were related to psychosocial problems, although presented to the provider in the form of physical complaints. Klonoff and Landrine (1997) accumulated evidence that as many as 41% to 83% of psychiatric patients instead suffer from an undiagnosed medical illness.

These numbers show that counselors must be aware of clients' physical needs as much as medical providers need to consider patients' emotional state. Both medical and psychological providers often fail to consider the possibility that clients presenting for one reason (e.g., medical concerns or psychological problems) may also or instead suffer from a condition in the realm of the other provider (Wickramasekera et al., 1996). These oversights could be prevented if both providers were more willing to consider the importance of the other and more open to working collaboratively (Brems, 2000). Doubtless, such collaboration enhances the quality of treatment (and life) of clients who are in need of medical *and* psychological interventions. Not surprisingly, lawsuits increasingly are brought against psychological providers who failed to investigate possible underlying physical diagnoses that would have explained a client's psychological symptoms (Klonoff & Landrine, 1997). Thus, for the sake of their clients and to minimize their own risk of being sued for malpractice, counselors need to be knowledgeable about medical referrals and have collaborative relationships with medical providers. This means raising their awareness of physical and psychological symptoms that should stimulate

referrals (Samson, Levin, & Richardson, 1998; White, Marans, & Krengel, 1998).

PSYCHOLOGICAL SYMPTOMS THAT REQUIRE MEDICAL DIFFERENTIAL DIAGNOSIS

Not making appropriate medical referrals when psychological symptoms have medical causes can lead to lack of problem resolution at best and life-threatening situations at worst. Thus, it is crucial that counselors be aware of possible differential medical diagnoses. Psychological symptoms that should stimulate data gathering for possible medical referral follow, with medical causes to be ruled out in parentheses:

- Anorexia Nervosa (e.g., Crohn's disease, hypopituitarism, systemic lupus erythematosus).
- Delirium (e.g., drug toxicity or withdrawal, metabolic disease, psychosocial trauma or stress, postoperative and postictal states, CNS trauma, infection).
- Delusional Disorder (e.g., metabolic/endocrine disorder such as thyroid disturbance, CNS lupus, hypopituitarism, Cushing's syndrome; neurological disorders such as temporal lobe epilepsy; Wilson's disease).
- Dementia (e.g., primary dementia such as Alzheimer's disease, Pick's disease, Creutzfeldt-Jakob disease; endocrine disorder; infections, including HIV; tumors, mainly in central nervous system; neurological disorder such as Huntington's Chorea, Parkinson's disease, palsy, subdural hematoma; nutritional deficiencies; vascular disorders; toxicities; head trauma).
- Generalized Anxiety (e.g., cardiovascular disease such as arrhythmias, coronary artery disease, hypertension, mitral valve prolapse; respiratory disease such as asthma, hyperventilation, chronic obstructive lung disease, pulmonary embolus; endocrine/metabolic disorders such as hypoglycemia, hyper- or hypothyroidism, hyponatremia; neurological disorders such as tumors, infection, complex partial seizures, migraines; peptic ulcers and ulcerative colitis).
- Major Depression (e.g., malignancies; CNS impairment such as uremia, demyelination, hypoxia, hepatic encephalopathy, infections such as hepatitis, mononucleosis, syphilis; nutritional deficiencies; endocrine disorders such as hypo- and hyperthyroidism, diabetes, pituitary insufficiency, Cushing's syndrome, Addison's disease).
- Mania (e.g., hypo- or hyperthyroidism, diencephalic or frontal stroke, multiple sclerosis, complex partial seizures, brain tumors).
- Panic Disorder (e.g., cardiovascular disease, especially mitral valve prolapse; respiratory disease; neurological disease; endocrine disorder; pheochromocytoma).
- Psychogenic Amnesia (e.g., organic amnestic disorder, epilepsy, postconcussion amnesia, substance-induced amnesia).
- Psychogenic Fugue (e.g., organic mental disorder, complex partial seizures, malingering).
- Schizophrenia (e.g., epilepsy, partial complex seizures, CNS tumor or infection, CNS degenerative disease, B_{12} and/or folic acid deficiency, endocrine/metabolic disease, toxicity, multiple sclerosis).
- Sexual Dysfunction (e.g., neurophysiological factors, side effect of drug or medication use, general medical illness).
- Insomnia (e.g., organic factors such as Parkinson's disease; cardiovascular insufficiency; respiratory disease).
- Parasomnia (e.g., endocrine disorders, diabetes mellitus, vascular disorder, neural disorders, epileptic seizures).

ADDITIONAL HINTS TO IDENTIFY THE NEED FOR MEDICAL REFERRAL

Beyond using symptoms, several hints help identify the need for medical referral. When a client presents with *inconsistent symptoms,* physical disorder needs to be suspected. For example, if a client complains of fatigue, lack of appetite, and sexual disinterest, but claims no other symptoms consistent with

depressive disorder, medical evaluation is indicated given the lack of consistency to support a pure psychiatric diagnosis of depression (i.e., never use "atypical" diagnoses without medical corroboration). When a client who has been seen for a while suddenly develops *new, more, or more severe symptoms,* a medical referral is warranted. Morrison (1997) warns that counselors must "think outside the mental health box" (p. 2), especially with clients they have seen for some time. When sudden symptomatic changes occur, it is the responsibility of the counselor to begin to question whether the pure mental health diagnosis truly accounts for the entire clinical picture. Another cue to the need for medical referral can be *unusual or changing appearance or mannerisms* (Morrison, 1997). Examples include features such as premature or nonmale pattern thinning of hair (e.g., hypothyroidism, malnutrition, or liver failure), darkening of skin (e.g., adrenal insufficiency or hypothyroidism), stiff or halting movements (e.g., fibromyalgia or Creutzfeldt-Jakob disease), shortness of breath (e.g., B_1 deficiency or congestive heart failure), or tremors (e.g., Parkinson's disease, multiple sclerosis, or hypoglycemia). Any *alarming symptoms,* such as blood in sputum or stool, persistent headaches, or similar severe or sudden physical manifestations also always warrant medical referral, even if the client does not connect them to the psychological presenting symptoms. Klonoff and Landrine (1997) suggest that "*visual illusions or hallucinations* always have an organic, rather than functional or psychiatric, etiology" (p. 59), and hence always require a medical referral. In fact, these authors indicate that basic physical exams should be required of all psychotherapy clients. Finally, when in doubt, refer.

FEATURES OF THE SUCCESSFUL REFERRAL PROCESS

If a client meets a criterion for medical referral, counselors need to explore whether the client received a recent (within the past one to three months) medical evaluation that assessed *relevant* medical disorders. If so, the counselor requests a release of information (ROI) from the client to access this medical information. Only a medical provider can make a medical diagnosis, especially as many differential diagnoses rely not solely on a simple medical exam, but require in-depth and protracted medical testing and evaluation. Table 2.1, based on Morrison's (1997) *When Psychological Problems Mask Medical Disorders* and Klonoff and Landrine's (1997) *Preventing Misdiagnosis of Women,* lists the most common physical disorders with psychological manifestations and actions necessary to rule them out. Knowing which medical tests are typically used helps counselors decide whether the client's medical exam targeted the current presenting symptoms. This is necessary to confirm that at the time of the physical exam the medical professional was aware of the psychological symptoms and ruled out the relevant medical issues. This thoroughness is suggested because not all clients are truthful and not all medical providers are equally qualified.

The referral process itself is straightforward. The client is made aware of the need for the medical referral, prepared for the medical contact, given a referral name if he or she does not have a regular medical provider, and asked to sign an ROI to allow communication between the medical provider and counselor. When making referrals to physicians, physician's assistants, nutritionists, nurse practitioners, and so forth, counselors have the responsibility to coordinate and facilitate this process for their clients. To prepare for their role as facilitators, counselors should enhance communication with physicians. First, it is recommended that counselors *identify medical specialists* with whom they can collaborate easily. Klonoff and Landrine (1997) recommend that this list optimally include an endocrinologist, a neurologist, a gynecologist, and an internist. Counselors need to be prepared to *provide hypotheses* about what might be going on with the client, providing concrete ideas of differential diagnoses based on physical data. To do so, they need to *learn basic medical jargon* that allows for communication and engenders respect. Medical providers will take a nonmedical referral source more seriously if he or she

TABLE 2.1 Physical Disorders with Psychological Symptoms

Disorder	Psychological Symptoms	Physical Symptoms	Medical Tests
Adrenal insufficiency (Addison's disease)	Fatigue, apathy, depression, social withdrawal, anxiety, suicidality, psychosis, poverty of thought, recent memory impairment	Weakness, darkening skin, nausea, abdominal pain, fainting, vomiting, weight loss, anorexia (loss of appetite)	History of salt cravings, urine or sputum test measuring cortisol levels
Amyotropic lateral sclerosis (Lou Gehrig's disease)	Depression, dementia	Muscle weakness, weight loss, ataxia (inability to coordinate voluntary muscle movement), dysarthria (inability to articulate words), cramping	Electromyography (to show muscle twitching)
Brain abscess	Lethargy, cognitive changes and symptoms	Headache, fever, stiff neck, seizures, nausea, vomiting, focal neurological symptoms	CT scan, MRI
Brain tumor	Loss of memory, cognitive changes, dementia, depression, psychosis, dissociation, personality changes	Headaches, vomiting, dizziness, seizures, focal neurological symptoms	CT scan, MRI, brain biopsy
Carcinoid syndrome	Flushing of the face and body (blushing)	Diarrhea, abdominal pain, blood-containing stool	Urine sample to assess high levels of serotonin breakdown products
Cardiac arrhythmia	Anxiety, delirium	Fatigue, dizziness, delirium, palpitations	Electrocardiogram
Chronic obstructive lung disease	Anxiety, panic, depression, insomnia, delirium	Cough, shortness of breath, tremor, headache, dark skin hue	Pulmonary function studies, blood-gas determination
Congestive heart failure	Anxiety, panic, insomnia, delirium, depression	Shortness of breath, fatigue, edema, cold, weakness, cyanosis	Chest X-ray, echocardiogram
Cryptococcus	Irritability, disorientation, mania, dementia, psychosis	Headache, fever, stiff neck, blurred vision, nausea, staggering gait	Search for causative yeast organism in cerebrospinal fluid bathed in india ink
Cushing's syndrome	Emotional lability, depression, anxiety, loss of libido, delirium, irritability, paranoid delusion, suicidality (high risk)	Hypertension, amenorrhea (cessation of menstruation), oily skin, increased body hair, weakness, facial and truncal obesity, buffalo hump	Physical exam, corticosteroid level in 24-hour urine specimen, history of steroid-containing substances
Diabetes mellitus	Fatigue, lethargy, panic, depression, poor concentration, delirium	Increased hunger, thirst, and urine output; rapid weight loss; blurred vision	At least two abnormal glucose tolerance tests
Fibromyalgia	Chronic fatigue, depression, anxiety	Muscle pain, stiffness, and tenderness	By history and symptom presentation

(continued)

TABLE 2.1 *Continued*

Disorder	Psychological Symptoms	Physical Symptoms	Medical Tests
Head trauma	Personality change, delirium, dementia, amnesia, mood swings, psychosis, anxiety	Headache, dizziness, fatigue, paralysis, seizures, anosmia (loss of sense of smell)	Skull X-ray, MRI, CT scan
Herpes encephalitis	Forgetfulness, anxiety, psychosis	Fever, headache, stiff neck, vomiting, focal neurological symptoms	Electroencephalogram, brain biopsy, CT scan
Homocystinuria	Mental retardation, dementia, behavioral problems	Impaired vision, shuffling gait, blotchy skin	Blood or urine test to check for elevated levels of homocysteine and methionine
Huntington's disease	Apathy, depression, irritability, impulsive behavior, personality changes, cognitive changes, suicidality, dementia	Insomnia, restlessness, ataxia, inarticulate speech, good appetite with weight loss, clumsiness, writhing motions of the limbs	Family history of this fatal disease, genetic testing
Hyperparathyroidism (Hypercalcemia)	Personality change, depression, anxiety, suicidality, delirium, psychosis; often mistaken for hypochondriasis	Urinary tract infections, weakness, tiredness, anorexia, nausea, vomiting, thirst, constipation, muscle and abdominal pain	Blood test to establish high serum calcium and parathyroid hormone levels
Hypertensive encephalopathy	Paranoia, delirium	Headache, nausea, paralysis, vomiting, visual impairment, seizures	Measurement of blood pressure (presence of hypertension)
Hyperthyroidism	Agitated depression, depression, anxiety, panic, delirium, psychosis; often mistaken for Bipolar Disorder	Goiter, red and puffy eyelids, bulging eyes, weakness, palpitations, hunger, tremor, warm, increased appetite with weight loss, diarrhea	Thyroid panel (blood test) to check for elevation of serum thyroxine levels and drop in thyroid stimulating hormone
Hypoglycemia	Anxiety, depersonalization, lethargy, fatigue	Sweating, palpitations, tremulousness, headache, confusion	Food diary, 5-hour fasting glucose tolerance test
Hypoparathyroidism (Hypocalcemia)	Irritability, mental retardation, depression, anxiety, paranoia, delirium, dementia	Numbness, tingling, and spasms in hands, feet, and throat; headaches; thin, patchy hair; poor tooth development	Blood test to establish low serum calcium and parathyroid hormone levels
Hypopituitarism	Apathy, indifference, fatigue, depression, decreased libido, drowsiness; often mistaken for Dependent Personality Disorder or psychotic depression	Waxy skin, loss of body hair, inability to tan, loss of appetite and weight, loss of nipple pigmentation, premature wrinkles around eyes and mouth	X-ray, CT scan, or MRI to establish structural pituitary abnormality; blood test to establish hormonal deficiencies

TABLE 2.1 *Continued*

Disorder	Psychological Symptoms	Physical Symptoms	Medical Tests
Hypothyroidism	Apathy, depression, suicidality, slowed cognitive function, dementia; mistaken for rapid-cycling Bipolar Disorder	Dry and brittle hair, dry skin, hair loss, edema, cold intolerance, appetite loss with weight gain, goiter, constipation, hoarseness, hearing loss, slow heartbeat	Blood test to establish drop in serum thyroxine and elevation in thyroid stimulating hormone levels; measurement of basal body temperature on five consecutive mornings
Lyme disease	Depression, psychosis, anxiety, mild cognitive symptoms	Headache, fever, chills, fatigue, stiff neck, malaise, achiness	History of tick bite, serum antibody response to B. Burgdorferi
Meniere's syndrome	Anxiety, panic, depression, poor concentration	Dizziness, nausea, vomiting, tinnitus (ringing in the ears), nystagmus (rapid, involuntary eyeball oscillation), deafness	Diagnosis based on symptoms
Mitral valve prolapse	Panic (do not use anxiolytics)	Chest pain, fainting, palpitations, breathlessness	Echocardiogram
Multiple sclerosis	Depression, mania, sudden emotionality, cognitive impairment, dementia; misdiagnosed as somatization or Histrionic Personality Disorder	Ataxia, numbness, weakness, fatigue, visual problems, incontinence, trouble walking, paresthesias (tingling or prickling of skin)	MRI to show areas of plaque; birthplace north of 55° latitude; hot bath test (weakness and faintness after hot bath)
Myasthenia gravis	Anxiety, memory loss, minor cognitive symptoms	Muscle weakness	Tensilon test (injection of edrophonium to check for briefly improved muscle strength)
Niacin deficiency (Pellagra)	Depression, anxiety, delirium, dementia	Weakness, anorexia, headache, diarrhea, red and rough skin	Food diary, based on symptoms, urine test
Pancreatic cancer	Depression, initial insomnia, crying spells, suicidality, anxiety, hypersomnia	Weight loss, weakness, abdominal pain, insomnia, hypersomnia	Ultrasound, CT scan, or endoscopic retrograde pancreatography; needle biopsy
Parkinson's disease	Depression, anxiety, impaired attention, cognitive deficits, paranoia; visual hallucinations as side effect of medications	Tremor, muscle rigidity, decreased mobility, masked facies, trouble walking, poor fine motor coordination	Based on symptoms and physical exam
Pernicious anemia	Forgetfulness, depression, dementia, psychosis	Anemia, dizziness, tinnitus, glossy tongue, palpitations	Blood test
Pheochromocytoma	Anxiety, panic	Headache, sweating, palpitations, nausea, high blood pressure	24-hour urine test for high catecholamine levels

(continued)

TABLE 2.1 *Continued*

Disorder	Psychological Symptoms	Physical Symptoms	Medical Tests
Porphyria	Depression, mania, euphoria, anxiety, delirium, psychosis	Abdominal pain, muscle weakness, tremors, dark urine, vomiting, seizures, sweating	Blood or urine test to check for high levels of porphobilinogen
Posterolateral sclerosis	Anxiety, weakness, memory impairment, psychosis; mistaken for Conversion Disorder	Heavy limbs, stocking and/or glove sensory loss, alteration in reflexes	Electromyography
Prion disease	Anxiety, fatigue, poor concentration, slowed mental function	Difficulty walking, tremors, muscle rigidity, hypokinesia (decreased muscle movement)	Electroencephalogram, history of ingestion of infected meat
Progressive supranuclear palsy	Slowed mental function, forgetfulness, apathy, labile mood	Double vision, unsteady gait, muscle stiffening	CT scan showing atrophy of pons and midbrain
Protein energy malnutrition	Apathy, lethargy, cognitive changes	Weight loss; loss of skin elasticity; dry, thin hair; low body temperature, heart rate, and blood pressure	Food diary, physical exam, blood test for low serum protein levels
Sleep apnea	Insomnia, depression, drowsiness, irritability, poor concentration	Snoring, morning headache, nocturia (nighttime urination)	Sleep polysomnography
Syphilis	Personality changes, fatigue, irritability, grandiosity, cognitive symptoms, psychosis	Ulcerous chancre, fever, headache, sore throat, skin rash, swollen lymph nodes	Serum screening test and serum fluorescent treponeme antibody absorption test
Systemic lupus erythematosus	Severe depression, cognitive symptoms, anorexia, psychosis (thorazine exacerbates symptoms)	Muscle and joint pain, butterfly rash, fatigue, fever, loss of appetite, nausea, vomiting, weight loss	Blood test to establish elevation of antinuclear antibodies
Thiamine deficiency (Beriberi)	Fatigue, irritability, anxiety, delirium, amnesia	Shortness of breath, edema, rapid heartbeat, nystagmus, trouble walking, fever, vomiting	History of alcoholism, food diary, MRI, CT scan, blood/urine tests
Wilson's disease (Inherited copper toxicosis)	Anxiety, personality change, irritability, anger, loss of inhibition, psychosis, depression, cognitive symptoms	Dysarthria, tremor, spasticity, rigidity, trouble swallowing, dystonia (poor tonicity of tissue), drooling	Liver function test (excess copper), blood tests (deficient copper-protein ceruloplasmin), MRI, CT scan

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refers to the *client as patient* (Klonoff & Landrine, 1997). Obtaining *basic preliminary physical data* from the client also expedites the referral and increases the likelihood of correct medical diagnosis. Preliminary physical data may be gleaned through an interview and consists of information such as weight patterns, sleep patterns, changes in physical functioning, substance use, and specific physical symptoms and their context (Brems, 1999). The more physical data counselors can offer, the more seriously they and the referral will be

taken by the physician (Klonoff & Landrine, 1997). Presenting this wealth of medical information in the most *concise and brief* manner, as opposed to embedded in a lengthy psychosocial history, will reap the greatest benefit (Diamond, 1998). Finally, it is important that counselors *never pretend to understand information* when in reality they do not. Asking questions to be informed about clients' medical conditions and the medical tests they may be facing is essential for optimal rapport. If counselors do not understand what their clients will encounter, they cannot help them prepare.

PLANNING TREATMENT AFTER A COMPLETED MEDICAL REFERRAL

If the medical provider rules out physical or medical causes for the client's presenting concerns, the counselor makes a proper mental health treatment plan focusing on the client's psychological symptoms, comfortable in the knowledge that no medical concerns are present. If, however, an underlying medical diagnosis completely or partially causes the psychological symptoms, counselor and physician collaborate to determine the optimal course of action. Medical symptoms are best treated by the medical provider; however, the sequellae of having a medical disorder that has emotional consequences are best treated by the counselor. Psychological treatment with a client who has an underlying medical illness will be different from counseling a client with psychological symptoms without medical causes. For the client with both concerns, counseling requires different goals and will largely be influenced by the severity, acuity, and chronicity of the medical illness. Close monitoring of the client's physical condition will be necessary, as will the counselor's need to learn more about the client's particular illness. Again, collaboration with the medical provider in this regard is emphasized.

References

Brems, C. (1999). *Psychotherapy: Processes and techniques.* Boston: Allyn & Bacon.

Brems, C. (2000). *Dealing with challenges in psychotherapy and counseling.* Pacific Grove, CA: Brooks/Cole.

Diamond, R.J. (1998). *Instant psychopharmacology: A guide for the nonmedical mental health professional.* New York: Norton.

Klonoff, E.A., & Landrine, H. (1997). *Preventing misdiagnosis of women: A guide to physical disorders that have psychiatric symptoms.* Thousand Oaks, CA: Sage.

Morrison, J. (1997). *When psychological problems mask medical disorders: A guide for psychotherapists.* New York: Guilford Press.

Samson, J.A., Levin, R.M., & Richardson, G.S. (1998). Psychological symptoms in endocrine disorders. In P.M. Kleespies (Ed.), *Emergencies in mental health practice* (pp. 332–354). New York: Guilford Press.

Tomb, D.A. (1995). *Psychiatry.* Baltimore: Williams & Wilkins.

White, R.F., Marans, K.S., & Krengel, M. (1998). Psychological/behavioral symptoms in neurological disorders. In P.M. Kleespies (Ed.), *Emergencies in mental health practice* (pp. 312–331). New York: Guilford Press.

Wickramasekera, I., Davies, T.E., & Davies, S.M. (1996). Applied psychophysiology: A bridge between the biomedical model and the biopsychosocial model in family medicine. *Professional Psychology: Research and Practice, 27,* 221–233.

3 COUNSELING WITH UNEMPLOYED AND UNDEREMPLOYED CLIENTS

Ellen B. Lent

> And when we have time on our hands,
> We have a pastime
> Wherein we try to have a good time,
> Even a grand time,
> Or perhaps the time of our life.
>
> *(Bolles, 2000, p. xii)*

In the best of all worlds, our work is the time of our life. The emotional experience of satisfying work may protect us from negative mental health outcomes and physical health complaints (Lent, 1995). When work fails to be the time of our clients' lives, a counseling intervention may be useful. The purpose of this chapter is to focus attention on what is known about responsible and ethical practices in counseling adult clients who have lost a job or who complain of being underemployed.

Underemployment is defined here as less-than-optimum use of an individual's capacities at work. Possible companions of underemployment include boredom and loss of dignity (Hansen, 1997), uncertainty (Landy, 1992), anxiety (Osipow & Fitzgerald, 1996), and low self-confidence (Shullman & Carder, 1983). Depression, anxiety, substance use, and other unwanted behaviors have been seen with chronic and acute joblessness and job dissatisfaction (Locke & Latham, 1990). *Unwanted unemployment* and underemployment can themselves be life stressors and can reduce people's ability to handle other stressors. In addition, the absence of income is an important stressor for most unemployed clients.

Concepts related to unemployed and underemployed individuals fall into one of the following categories: *internal,* or unique to the person; and *external,* including availability of work, development opportunities, bias and other unjust barriers related to clients' demographic features, and access to technology.

INTERNAL ISSUES

Factors often included in models of job and career psychology include interests, values, skills, decisiveness, and maturity. When a client is at liberty to choose among available and attractive work options, these factors can be very useful in counseling. However, when clients are in distress about work, additional internal factors such as well-being, self-efficacy, work strain, and other emotional and cognitive stressors may be more prominent.

Well-being is defined as the belief that one is living a good and worthwhile life, accompanied by the presence of positive feelings and the relative absence of negative feelings (Diener, 2000). Job satisfaction is a component of well-being. Satisfaction with one's job, more than working conditions or supervision, may be closely related to clients' mental health (Osipow & Fitzgerald, 1996).

A facet of well-being relevant to work roles is the ability to be flexible in setting goals. Because becoming and staying employed relies partly on factors outside of one's individual control, the willingness to adjust and change goals is an important factor in difficult circumstances (Diener, 2000). How people adapt to changing conditions helps to indicate their

ability to benefit from counseling and reach their goals.

Clients' level of *self-efficacy,* or belief in their ability to complete certain actions, can indicate their willingness to engage in a job search. They may doubt their own competence and worth and question their ability to find a new job or improve their present working conditions. Underemployed clients may believe that their talents are not valued. Job search self-efficacy has been found to predict actual job searching better than general self-esteem and sense of control (Saks & Ashforth, 1999). The setting of specific goals and a belief in positive outcomes are important aspects of job search self-efficacy that may help predict the success of counseling interventions.

Reduced self-efficacy and self-esteem can interfere with individuals' plans to identify and act on their interests in the workplace (Betz, 1999). If clients are not confident of their "match" with particular jobs or work settings, they risk giving up in the face of barriers such as discrimination or lack of training.

Work strain refers to problems with work tasks, demands, and relationships. It can include being over- or underworked; having conflict in work relationships, feeling unprepared for new work tasks, and having multiple demands at work and in other life roles. Workers with outdated skills may describe being underutilized or bored. Clients may sometimes report lack of interest when they are actually feeling depressed or anxious about their work or the upcoming job search. Use of caffeine and nicotine may alleviate boredom due to monotonous work tasks (Landy, 1992).

Other Emotional and Cognitive Stressors

A significant proportion of recipients of public assistance are homeless, have chronic physical or mental health problems or drug or alcohol problems, and are survivors of serious abuse (Edwards, Rachal, & Dixon, 1999). Intellectual and cognitive deficits may be present as well. Because many of these adults are now entering the workforce, it is more likely that counselors will see these issues in clients presenting with employment concerns. In addition, the loss of a job or chronic underemployment may be stressful enough to contribute to a depressed or anxious mood, behavior disruptions, and other negative symptoms.

The state of being employed can itself be significant: "Almost any type of work, regardless of how much of an underload or overload it represents, has the capacity to relieve depression in some people" (Landy, 1992, p. 137). Unemployment can precipitate depression, anxiety, substance abuse, and other serious disorders in some people.

For clients experiencing an unwanted job loss or chronic underemployment, searching for a new position may propel them into counseling. After issues such as those above are resolved or ruled out, general factors in job transition are useful to address.

Interests

There is a huge literature on assessing and measuring vocational interests, underscoring the perceived importance of interests when counseling adults on work transitions. Interests are measured by a variety of available inventories that can help clients to "focus attention, arouse feelings, and steer a direction" (Savickas & Spokane, 1999, p. 6). The reliability and validity of interest inventories for various cultural and ethnic groups is still under study. Interests can also be assessed by card sorts and other methods of self-report (cf. Peterson, 1998). Research has amply demonstrated their stability—and there is a strong genetic component to individual interests (cf. Betsworth & Fouad, 1997; Swanson & Gore, 2000)—but it is not yet known how much change in interests is possible over time and across different activity settings. Understanding clients' interests does not tell the entire story in a counseling intervention. Individual *values* are also important factors in work transition. Status, comfort, and safety may rank higher than altruism, achievement, and autonomy in a job change decision, citing one set of values often applied to the work setting (Dawis & Lofquist, 1984). The role of meaning in work also plays a part in many people's cognitive and

emotional responses to unwanted job loss or underutilization.

People's *skill* levels are often deduced by examining test scores, academic grades, letters of reference, and other unique indicators. Standardized scores of aptitude and achievement are also used in some settings. Prediction of future job performance can be attempted by these means, but concerns exist about the effects on disadvantaged job candidates (Osipow & Fitzgerald, 1996). The variable nature of performance appraisals in the workplace, with multiple raters of uncertain quality and motivation, makes skill level a factor that may straddle internal and external categories. It is clear, however, that ability and skill feedback contributes importantly to people's self-concepts and beliefs about their work interests and choices.

The level of *decidedness* with which clients approach job and career choice has received significant attention. Less is known about the role of decidedness in adults who have been employed but are seeking a new job. Theories of coping methods in responding to chronic stress include an emphasis on decision making (cf. Folkman & Moskowitz, 2000). Indecisiveness can signal emotional conflicts or obstacles to making choices (Savickas, 1996). Self-efficacy for making decisions can help or hinder the process; for instance, beliefs in one's ability to find acceptable job options and choose among them predicts employment (Saks & Ashforth, 1999).

A well-known definition of *vocational maturity* encompasses a number of tasks relevant to choosing an occupation or work setting. Defined by Donald Super and his colleagues, it includes an evaluation of interests, behaviors, values, and knowledge said to aid in vocational planning and choice (Thompson, Lindeman, Super, Jordaan, & Myers, 1981).

EXTERNAL ISSUES

A variety of factors external to clients may impact on counseling assessment and treatment. *Availability of work* is relevant to everyone, but is even more important as the U.S. and the global economy shift further toward information technology and biotechnology and away from manufacturing and many service occupations. Two million white-collar jobs change dramatically or disappear in the United States every year, and a significant number of blue-collar jobs incorporate new levels of computer-related skills (Rifkin, 1995).

Access to job networks and promotional opportunities is a crucial factor relevant to counseling the unemployed and underemployed. Bias, discrimination, and other barriers can affect a significant proportion of hopeful workers. Persons of low social class represent one such vulnerable group. A home address from a poor neighborhood can destine a job application for the recycling bin (Wilson, 1996). Discrimination on the basis of age, gender, race, disability, sexual orientation, and other demographics renders many others vulnerable as well. These conditions can lower self-efficacy and expectations for success.

Access to learning and new skill development is crucial to remaining employable and having a positive work experience. Persons reporting no on-the-job development, training, or learning are at risk of unemployment or underemployment due to skill obsolescence.

Technology access increasingly dictates the amount of job information available and the speed with which it is obtained. Many potential employers request resumes strictly by electronic transmission, containing key words that are recognizable by computer programs that route them to the most appropriate recipient. With sufficient economic means, people can subscribe to services that remotely search job listings throughout the World Wide Web, delivering the most relevant openings directly to their e-mail address on a daily basis. Clients with little or no technology access may be left out of this avenue of job searching.

Social support has been shown to reduce the effects of stress in many different domains. Gaining the support of important others is a significant aspect of lessening the stress and overcoming the barriers of underemployment and unemployment. It has been suggested that aiding clients in finding and gathering supportive others yields more benefit than

focusing on removing barriers in job search and work transitions (Brown & Krane, 2000).

COUNSELING PROCESS FACTORS

What counselors bring to the counseling relationship—their assumptions, values, methods, and intervention choices—deserve mention in this discussion. Evaluating clients nondirectively aids in keeping counselor biases and assumptions at a minimum (Lent, 1996). Structural obstacles such as discrimination must be explored from the client's perspective. The type of intervention recommended may be highly informational, highly therapeutic, or a combination of both. Counselors may find that collaboration with bachelor's-level career development facilitators (Splete & Hoppin, 2000) and other trained personnel works to their advantage in efficient provision of services.

Confidentiality and privacy must be clearly described and carefully guarded, especially when telephone or computer lines are involved (including telephone counseling and coaching and inventories completed via Web sites). The validity and reliability of inventories and other instruments must be determined and delivered by those trained and competent in their use.

There is some evidence that in establishing and maintaining a counseling relationship, the focus on a specific task and goals for clients to accomplish is of greater import than a therapeutic bond between counselor and client (Warwar & Greenberg, 2000). On the other hand, a resurgence of interest in therapeutic empathy encourages focus on counselor-client interactions. Narrative counseling techniques highlight the stories that clients tell and suggest methods for actively "writing" new portions in the context of counseling.

COUNSELING RECOMMENDATIONS

One definition of counseling for work concerns encompasses a number of the themes mentioned in this chapter: "Helping people make goal-congruent work or career choices that will allow them to experience work, career, and life satisfaction in a changing society" (Brown & Krane, 2000, p. 740). A client-centered assessment aids in understanding the full scope of clients' needs, goals, satisfiers, and interests in the world of work. It can also encourage discussion of external and internal obstacles that may be holding clients back from feeling confident and taking action. Counselors can evaluate sense of competence or self-efficacy by asking clients if they believe they can perform actual job search behaviors, such as revising a resume or finding job leads. This can lead to specific action steps that should improve clients' belief in their abilities.

Counselors can initiate discussion of bias, discrimination, and other societal obstacles in their assessment. Expectations about salary, benefits, promotion and training opportunities, and level of autonomy or responsibility may be affected by clients' social class, race, gender, age, and other demographic features.

Many clients seeking work transition counseling expect to be given testing, which will indicate their best work choices. Placing responsibility for this process on an external resource can be indicative of anxiety regarding the task. Because a major cause of early termination from career counseling is anxiety, it is advisable to engage clients in a thorough assessment and explore potential emotional barriers before embarking on a structured exploration of interests, skills, and work values. At the end of this process, the match between clients' needs and talents should be maximized, "so that their aspirations are aimed as high as their ability will take them" (Brown & Krane, 2000, p. 751).

Two Notes of Caution

Clients may inform you that they have completed career inventories on the Internet and that they have taken action based on the results. Remote administration of these instruments can be fraught with pitfalls (cf. Sampson & Lumsden, 2000):

- Clients' unique issues may not have been assessed initially.

- The norm groups for the instrument may not represent the client demographically.
- The person who administered or scored the instrument may not be adequately trained.
- Clients may have completed the instrument in an environment not conducive to reliable results; for instance, with interruptions or other challenges to concentration.
- Clients' privacy may not have been protected, and they may begin to receive unsolicited marketing materials linked to their individual responses.
- The inventory results might not have been reported in a way that allowed clients' full understanding or follow-up discussion.

A second cautionary topic is the unanswered question of the long-term usefulness of counseling adults in work transitions. Studies have shown that people using counseling and allied services are more satisfied with job choice, values clarification, and other immediate outcomes. However, research has not effectively demonstrated that people who obtain career or job counseling are more satisfied with their work, their life, or other related outcomes in the long run (Brown & Krane, 2000). This question deserves further study to determine the ideal amount of effort that should be expended on program design, counseling processes, structured activities and instruments, and other services designed to help people have the time of their lives in the workplace.

Tests and Inventories

Published instruments often enrich the counseling process for clients who have minimal conflicts and obstacles. Among the many instruments in use for adults making work transitions, the following titles may be useful after a careful assessment:

Adult Career Concerns Inventory (Super, Thompson, & Lindeman (1987).

Campbell Interests and Skills Survey (Campbell, 1994).

Career Decision-Making Self-Efficacy Scale (Betz, Klein, & Taylor, 1996).

Career Attitudes and Strategies Inventory—Career Obstacles Checklist and Job Satisfaction Scale (Holland & Gottfredson, 1994).

Kuder Career Search (Zytowski, 1999).

Myers-Briggs Type Indicator (Myers, McCaulley, Quenk, & Hammer, 1998).

Occupational Stress Inventory (Osipow & Spokane, 1987).

Self-Directed Search (Holland, 1994).

Strong Interest Inventory (Strong, Hansen, & Campbell, 1994).

Card sorts offer another structured way for counselors and clients to explore occupational interests. Manipulating cards with occupational titles can provide a novel activity in the counseling process. The following titles may be useful:

Deal Me In Cards (Farren, Kaye, & Leibowitz, 1985).

Occupational Interest Card Sort (Knowdell, 1993).

Missouri Occupational Card Sort (Krieshok, Hansen, & Johnston, 1989).

Slaney Vocational Card Sort (Slaney, 1978).

Vocational Exploration and Insight Kit (Holland & Associates, 1980).

Other resources worthy of attention follow:

Careerhub: www.careerhub.org. This Web site was designed in consultation with the University of California, Berkeley, as a stand-alone resource for career and job searchers. It offers free inventories that do not require a trained counselor's interpretation and provides guidance on when to seek a counselor. Access to copyrighted instruments and materials is available for a fee.

Joint special issue, *The Career Development Quarterly* and *The Journal of Employment Counseling:* Collaboration, Partnership, Policy, and Practice in Career Development. 48, June 2000: National Career Development Association.

Special issue, *Journal of Career Assessment:* Career Assessment and the Internet. 8, Winter 2000: Psychological Assessment Resources, Inc.

Handbook of Career Counseling Theory and Practice (2000). Edited by M.L. Savickas and W.B. Walsh. Palo Alto: Davies-Black.

What Color Is Your Parachute? (2000). Richard Bolles. Berkeley, CA: Ten Speed Press.

SUMMARY

Clients can report significant difficulty facing the stressors of underemployment or unemployment. Although not enough is known about the long-term effects of counseling for these issues, it is highly desirable to do a complete assessment and intervene promptly, addressing both internal and external factors related to work transitions. When emotionally ready, clients can benefit from structured adjuncts in counseling and targeted discussion of supports and obstacles to achieving satisfaction in their work lives.

References

Bettsworth, D.G., & Fouad, N.A. (1997). Vocational interests: A look at the past 70 years and a glance at the future. *Career Development Quarterly, 46,* 23–47.

Betz, N.E. (1999). Getting clients to act on their interests: Self-efficacy as a mediator of the implementation of vocational interests. In M.L. Savickas & A.R. Spokane (Eds.), *Vocational interests: Meaning, measurement and counseling use* (pp. 327–344). Palo Alto, CA: Davies-Black.

Betz, N.E., Klein, K.L., & Taylor, K.M. (1996). Evaluation of a short form of the Career Decision-Making Self-Efficacy Scale. *Journal of Career Assessment, 1,* 21–34.

Bolles, R.N. (2000). *What color is your parachute? A practical manual for job-hunters and career-changers.* Berkeley, CA: Ten Speed Press.

Brown, S.E., & Krane, N.E.R. (2000). Four (or five) sessions and a cloud of dust: Old assumptions and new observations about career counseling. In S.D. Brown & R.W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 740–766). New York: Wiley.

Campbell, D.P. (1994). *The Campbell Interests and Skills Survey.* Minneapolis, MN: National Computer Systems.

Dawis, R.V., & Lofquist, L.H. (1984). *A psychological theory of work adjustment: An individual-differences model and its applications.* Minneapolis: University of Minnesota Press.

Diener, E. (2000). Subjective well-being: The science of happiness and a proposal for a national index. *American Psychologist, 55,* 34–43.

Edwards, S.A., Rachal, K.C., & Dixon, D.N. (1999). Counseling psychology and welfare reform: Implications and opportunities. *The Counseling Psychologist, 27,* 263–284.

Farren, C., Kaye, B., & Leibowitz, Z. (1985). *Deal me in.* Silver Spring, MD: Career Systems.

Folkman, S., & Moskowitz, J.T. (2000). Positive affect and the other side of coping. *American Psychologist, 55,* 647–654.

Hansen, L.S. (1997). *Integrative life planning: Critical tasks for career development and changing life patterns.* San Francisco: Jossey-Bass.

Holland, J.L. (1994). *Self-directed search.* Odessa, FL: Psychological Assessment Resources.

Holland, J.L., & Gottfredson, G.D. (1994). *Career Attitudes and Strategies Inventory: An inventory for understanding adult careers.* Odessa, FL: Psychological Assessment Resources.

Holland, J.L., & Associates. (1980). *Counselor's guide to the Vocational Exploration and Insight Kit (VEIK).* Palo Alto, CA: Consulting Psychologists Press.

Knowdell, R.L. (1993). *Manual for Occupational Interests Card Sort Kit.* San Jose, CA: Career Research and Testing.

Krieshok, T.S., Hansen, R.N., & Johnston, J.A. (1989). *Missouri Occupational Card Sort manual.* Columbia: University of Missouri, Career Planning and Placement Center.

Landy, F.J. (1992). Work design and stress. In G.P. Keita & S.L. Sauter (Eds.), *Work and well-being: An agenda for the 1990s* (pp. 119–158). Washington, DC: American Psychological Association.

Lent, E.B. (1995, August). *Worklife efficacy: Prevention and intervention.* Paper presented at the third conference on Work Stress and Health, American Psychological Association and National Institute for Occupational Safety and Health, Washington, DC.

Lent, E.B. (1996). The person focus in career theory and practice. In M.L. Savickas & W.B. Walsh (Eds.), *Handbook of career counseling theory and practice* (pp. 109–120). Palo Alto, CA: Davies-Black.

Locke, E.A., & Latham, G.P. (1990). Work motivation and satisfaction: Light at the end of the tunnel. *Psychological Science, 1,* 240–246.

Myers, I.B., McCaulley, M.H., Quenk, N.L., & Hammer, A.L. (1998). *Myers-Briggs Type Indicator manual.* Palo Alto, CA: Consulting Psychologists Press.

Osipow, S.H., & Fitzgerald, L.F. (1996). *Theories of career development* (4th ed.). Boston: Allyn & Bacon.

Osipow, S.H., & Spokane, A.R. (1987). *Occupational Stress Inventory manual, research version.* Odessa, FL: Psychological Assessment Resources.

Peterson, G.W. (1998). Using a vocational card sort as an assessment of occupational knowledge. *Journal of Career Assessment, 6,* 49–67.

Rifkin, J. (1995). *The end of work: The decline of the global labor force and the dawn of the post-market era.* New York: Putnam.

Saks, A.M., & Ashforth, B.E. (1999). Effects of individual differences and job search behaviors on the employment status of recent university graduates. *Journal of Vocational Behavior, 54,* 335–349.

Saks, A.M., & Ashforth, B.E. (2000). Change in job search behaviors and employment outcomes. *Journal of Vocational Behavior, 56,* 277–287.

Sampson, J.P., Jr., & Lumsden, J.A. (2000). Ethical issues in the design and use of internet-based career assessment. *Journal of Career Assessment, 8,* 21–35.

Savickas, M.L. (1996). A framework for linking career theory and practice. In M.L. Savickas & W.B. Walsh (Eds.), *Handbook of career counseling theory and practice* (pp. 191–208). Palo Alto, CA: Davies-Black.

Savickas., M.L., & Spokane, A.R. (Eds.). (1999). *Vocational interests: Meaning, measurement and counseling use.* Palo Alto, CA: Davies-Black.

Shullman, S.L., & Carder, C.E. (1983). Vocational psychology in industrial settings. In W.B. Walsh & S.H. Osipow (Eds.), *Handbook of vocational psychology: Applications* (Vol. 2, pp. 141–180). Hillsdale, NJ: Erlbaum.

Slaney, R.B. (1978). Expressed and inventoried vocational interests: A comparison of instruments. *Journal of Counseling Psychology, 25,* 520–529.

Splete, H.H., & Hoppin, J.M. (2000). The emergence of career development facilitators. *Career Development Quarterly, 48,* 340–347.

Strong, E.K., Jr., Hansen, J.C., & Campbell, D. (1994). *Strong Interest Inventory.* Palo Alto, CA: Consulting Psychologists Press.

Super, D., Thompson, A., & Lindeman, R. (1987). *Manual for the Adult Career Concerns Inventory.* Palo Alto, CA: Consulting Psychologists Press.

Swanson, J.L., & Gore, P.A., Jr. (2000). Advances in vocational theory and research. In S.D. Brown & R.W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 233–269). New York: Wiley.

Thompson, A.S., Lindeman, R.H., Super, D.E., Jordaan, J.P., & Myers, R.A. (1981). *Career development inventory: Users manual.* Palo Alto, CA: Consulting Psychologists Press.

Warwar, S., & Greenberg, L.S. (2000). Advances in theories of change and counseling. In S.D. Brown & R.W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 571–600). New York: Wiley.

Watts, A.G. (2000). Career development and public policy. *Career Development Quarterly, 48,* 301–312.

Wilson, W.J. (1996). When work disappears: The world of the new urban poor. New York: Alfred A. Knopf.

Zytowski, D. (1999). *Kuder career search: Preview manual.* Adel, IA: National Career Assessment Services.

4 EFFECTIVE COLLEGE COUNSELING

Neal E. Lipsitz

The primary goal of the college environment is to promote learning and growth in students; such personal change requires adjustment, and the unique role of college counselors is to assist students in dealing with the developmental challenges that accompany personal growth. (Davis & Humphrey, 2000, p. 43)

COLLEGE COUNSELING CENTER MISSIONS AND FUNCTIONS

Addressing college counseling as a whole is difficult because just as every institution of higher education is distinct, so is every college counseling center. Counseling centers differ according to the type of college in which they reside (four-year/two-year, public/private, large/small), the school's mission, and the resources available to them. Five distinct types of centers were first identified by Whiteley, Mahaffey, and Geer (1987):

1. *Macrocenter.* Provides a wide range of clinical services such as personal and career counseling and testing, along with special functions including training and consultation with limited advising.
2. *Career planning and placement.* Career-oriented services with minimal counseling and other functions.
3. *Counseling orientation.* Similar to macrocenters but with fewer career services.
4. *General-level service.* Wider functions including "dean of students"-type functions, more services to a greater number of students than a conventional counseling center.
5. *Minimal service.* Minimal service provided in all areas.

More recently, however, Stone and Archer (1990) emphasize the wide variation in college counseling center design and function even within each category. For example, variation occurs when centers of the same type operate from different theoretical orientations (e.g., psychodynamic vs. cognitive-behavioral) or with various service limits (e.g., short-term vs. open-ended treatment modalities).

Because college counseling centers are not independent operations and serve only members of a college community, their success in meeting the needs of the community depends on the degree to which they focus their activities to mesh with the mission of the particular college (Bishop, 1991). Clearly, centers themselves also need an explicitly articulated philosophy to function well. As these philosophies are set in the context of different institutional histories, mission statements, and service offerings, counseling centers necessarily differ significantly.

Finally, there is great variation in college students themselves. Some schools are more homogeneously populated (e.g., in terms of student ages and cultural backgrounds) and others are more diverse. Because counseling centers must meet the needs of the students they serve, this too contributes to the differences among them.

Regardless of this variability, essential roles and functions for college counseling centers have been articulated and standardized. For example, the Standards and Guidelines for

Counseling Programs and Services by the Council for the Advancement of Standards in Higher Education (CAS, 1997) outline three major functions for college counseling centers: developmental, remedial, and preventive. The developmental function is aimed at helping students mature and succeed academically; the remedial function is designed to provide professional clinical services to students with significant personal adjustment problems; and the preventive function focuses on neutralizing environmental conditions that interfere with student welfare. The Accreditation Standards for University and College Counseling Centers by the International Association of Counseling Services (IACS) (Kiracofe et al., 1994) parallel those listed above. Stone and Archer (1990), CAS (1997), and IACS (Kiracofe et al., 1994) also suggest more specific recommendations, including consultation and outreach to a variety of groups in the campus community, staff development, crisis intervention, psychological and career testing, research, and evaluation of services.

THE SCOPE AND INTENSITY OF STUDENT NEEDS AND PROBLEMS

College students typically bring four kinds of issues with them to the college experience (Chandler & Gallagher, 1996):

Personal and social adjustment issues involving relationship difficulties, self-esteem, existential concerns, depression, sexual abuse and harassment.

Academic and career concerns.

Stress and psychosomatic symptoms, including anxiety.

Distressing symptoms related to substance abuse, sexual dysfunction, eating disorders, and unusual behavior.

Generally, the most prevalent issues include relationship difficulties, depression, anxiety, low self-esteem, stress, academic problems, and career concerns (Chandler & Gallagher, 1996). Even college counseling centers with fairly homogeneous student populations now find themselves challenged by the array of student problems because students on every campus today show a wider range of previous life experiences, cultural backgrounds, socioeconomic levels, interests, needs, developmental issues, and family structures. For example, a 31-year-old immigrant from Cambodia with a full-time job, an extended family to help support, and English as a second language is a more likely member of the first-year class today than in the past. In addition, a greater proportion of students are likely to have experienced mental health problems prior to college and to have sought professional help for those problems, including the use of medications (Altschuler, 2000). A recent study by the World Health Organization (2000) that examined 30,000 people from seven countries concluded that mental disorders are, in fact, becoming more widespread across every age level. The Cooperative Institutional Research Program survey (Sax, Astin, Korn, & Mahoney, 2000) found that among first-year students a sense of being "frequently" overwhelmed has grown steadily over the past 15 years (from 16% in 1985 to 31% in 1999).

Whether psychopathology among college students is truly more common has been extensively debated in the professional literature (Erickson Cornish, Riva, Henderson, Kominars, & McIntosh, 2000; Gilbert, 1992; O'Malley, Wheeler, Murphey, O'Connell, & Waldo, 1990; Pledge, Lapan, Heppner, Kivlighan, & Roehlke, 1998; Sharkin, 1997; Stone & Archer, 1990). R. Gallagher, Gill, and Sysko's (2000) survey of counseling center directors revealed that 222 of 286 (77.6%) believed that severe psychological problems have increased in students over the past five years. On the other hand, Pledge, et al., (1998) found that levels of student psychopathology had not increased since the late 1980s in their study of 2,000 college students between 1989 and 1995. These authors do suggest, however, that the mental health issues college students present to college counselors have become more consistently severe since the late 1980s. Sharkin (1997) argued that increased pathology in college students is not supported by

empirical data but is actually a reflection of the perception of college mental health clinicians. Cornish et al. (2000) concluded that it was not the overall level of distress of students that had increased, but a small increase in the amount of extremely distressed students accounted for the perceptions of a widespread increase in psychopathology among staff. Intuitively, this argument makes a lot of sense given the greater overall diversity of college students today, their varied backgrounds, and their potential for previous emotional health issues. A common challenge for college counselors today, then, is the successful management of what is perceived to be, and may in fact be, a more demanding clinical caseload than in the past (Davis & Humphrey, 2000; Stone & Archer, 1990).

Whatever the true figure for its frequency, effective treatment for students who present more serious psychopathology is possible only if counseling center staff are adequately trained to conduct thorough assessment, treatment planning, and direct intervention. Otherwise, referral into the community, or even refusal to treat, may be more in keeping with the best interests of the client. Moreover, the need for psychiatric consultation remains high for both assessment of psychopathology and medication evaluation/monitoring.

COMPETENCIES AND CHALLENGES FACING COLLEGE COUNSELORS

A related challenge is created by the breadth of service expected of college counseling center staff. The demands of clinical work are strong, yet it would not be prudent for staff to sit behind closed doors and wait for students to appear. In fact, a wide array of competencies are required of counseling center staff. Spooner, in Davis and Humphrey (2000), suggests that college counselors need to be professionally trained, multiculturally and technologically competent, creative at problem solving, and capable of maintaining their own physical, emotional, and spiritual equilibrium. Because of the increased diversity of the student body, Archer and Cooper (1998) identify a number of specific populations with whom college counselors need to exhibit competency:

Multicultural/international students.

Students with learning disabilities and attention deficits.

Older and nontraditional students, especially women returning to education.

Gay, lesbian, bisexual, and transgendered students.

College counselors also need the ability to be effective consultants to faculty, staff, parents, and the community, to provide meaningful and effective outreach to the campus community, and to provide helpful career counseling for students making the school-to-work transition. The suggestion that college counseling centers "move beyond the therapy office" is an often echoed theme (Davis & Humphrey, 2000; Stone & Archer, 1990; P. Gallagher & Demos, 1983) because it is so crucial to success in the competencies listed above. When students see staff doing outreach, consultation, crisis intervention, training, and the like, they tend to feel more comfortable about using the counseling center. This may be especially true for students from diverse cultural backgrounds, for whom trust may be more easily established after a significant exposure on a more informal basis. In other words, the major benefit from outreach is that it provides multiple ports of entry to the counseling center.

SPECIAL ETHICAL CHALLENGES IN COLLEGE COUNSELING

The diverse roles of the college counselor and the closed nature of the community this profession services present several important ethical challenges. Dual relationships are a distinct hazard, especially for counselors playing more than one role on campus (e.g., also teaching, advising a student organization, living on campus). Counselors must be cognizant of their role in each setting and set appropriate

boundaries around their immediate interactions with students. Maintaining confidentiality can be challenging when parents, deans, professors, or concerned peers are looking for information regarding a student they care about. If confidentiality is not adequately explained to other campus professionals, counselors can appear to be uncooperative and difficult. "Duty to warn" can provide a potential safeguard for a third party when a client reveals that he or she is immanently going to hurt the third party physically. Amada (1994) speaks to the unique issues that arise when college administrators refer disruptive students to the campus counseling center. Attempts to enact mandatory counseling by deans, judicial affairs officers, alcohol education personnel, and residence life staff, for example, are probably best met with offers to provide "information sessions" to these students if they would like to find out what the counseling center has to offer them. The guiding principle is to protect the privacy and dignity of the students as the highest priority but also to recognize the rights and responsibilities of faculty and administrators to the campus community.

INNOVATIONS AND EMERGING ISSUES

Brief therapy is a mode that has shown some efficacy in helping college counselors deal with the demand for services (Archer & Cooper, 1998). Even clients with more serious presenting problems appear to benefit from this approach, at least as a way to become prepared for more extensive therapy. And brief intermittent therapy is a natural approach for college students, as they are in a position to work on various issues in short order as they progress through their college years. In fact, the National Survey of Counseling Center Directors (P. Gallagher, Gill, Goldstrohm & Sysko, 1999) indicated that the average number of sessions per client was five, whether or not session limits were in place. As a fairly standard finding across college counseling centers nationwide, this statistic illustrates the developmental readiness that enables most college students to resolve rather quickly the problems that brought them into counseling. Of course, some college students are seen for longer-term counseling, and although that group generally uses up a relatively large portion of staff resources, they also represent a relatively small portion of each center's clinical population.

Crisis intervention plays a central role in the services rendered by college counseling centers. When students are in the midst of emotional crises (e.g., psychotic breaks, suicidal gestures or attempts, major grief reactions, sexual assaults, substance abuse crises), the campus community looks to professional staff from the counseling center to intervene. Therefore, it is imperative that an effective crisis response system be in place. This is often accomplished through a pager system enabling at least one member of the counseling center staff to be accessible at all times. Following a major catastrophe on campus (e.g., death of a student, multiple deaths in an accident, residence hall fire), it is helpful to have a crisis-catastrophic emergency and postvention plan. Counseling center staff should be prepared to play a central role in the response to such events. Of the 311 counseling center directors surveyed by P. Gallagher et al. (1999), 214 (70.4%) had a procedure in place for dealing with such incidents. A common model of response to traumatic incidents that can be adapted for use on a college campus is the Critical Incident Stress Management model (Mitchell & Everly, 1993).

College counseling centers have long been committed to viewing student issues in the context of the life transitions students are experiencing. This developmental perspective assumes that students approach their problems in a manner that is consistent with their level of development. Our job as college counselors, then, is to help students mature as they progress through the transitional issues they are facing. This is a health-oriented perspective rather than a psychopathological one. For example, first-year college students are generally dealing with issues related to leaving home and establishing a life independent of their families. Sophomores, having

left the novelty of first year behind, can feel lost, not knowing what direction to choose academically and/or relationally as they work to define themselves intrapersonally. Juniors often begin to feel the press of their adult lives after college starting to make an impact and deal with issues of commitment to potential career paths as well as relationships. Seniors, for whom graduation is in sight, often deal with issues related to leaving their college lives behind, moving into their career, and facing financial independence.

Counseling centers have long been encouraged to engage in research for accountability purposes (Stone & Archer, 1990). Bishop (1991) suggested that "successful efforts at strategic planning will . . . require the systematic collection of data about what a counseling center staff actually does and how well it performs its functions" (p. 408). He goes on to suggest that maintaining a database for self-study can help clarify problem areas so they can then be rectified. At a more basic level, data are necessary so that counseling centers can describe their activities to the decision makers at their institutions as well as understand student culture and the related demand on counseling services (Bishop, 1995).

In their follow-up to Stone and Archer's article on the challenges that college and university counseling centers faced in the 1990s, Guinee and Ness (2000) indicated that counseling centers are paying increased attention to accountability issues. They also report that centers can no longer compete for tight resources simply through data on students served or evidence of high levels of client satisfaction. These authors suggest that centers must assess the efficacy of their practices, study the demographics of their clients, and chart the actual severity of problem presentations in counseling center clients. However, Guinee and Ness also point out that little progress has actually been made in conducting systematic research in these areas over the past 15 years. More centers are beginning to use outcome questionnaires such as the Outcome Questionnaire-45.2 (OQ-45.2) (Lambert et al., 1996) or the Psychotherapy Outcome Assessment and Monitoring System (POAMS) (Kopta & Lowry, 2000). As this practice continues, along with the need to conduct needs assessments of students, perhaps increased attention to accountability issues will translate into informative research in this area.

Counseling centers will also need to assess the effectiveness of the many innovations that seem to be developing into standard practice. For example, national mental health screening days are more common on college campuses every year, and the breadth of screenings is increasing. Many campuses now offer depression, anxiety, alcohol, and eating disorders screening days on a yearly basis. Currently, little independent research on the impact of these events has been conducted.

Partnerships between college counseling centers and community agencies account for another innovation. To provide adequate services to students presenting with substance abuse, eating disorders, or sexual assault issues, ancillary services in the community are often warranted. Such services may include:

- A substance abuse center with detoxification capabilities for substance abusing students.
- Nutritional counseling, medical monitoring, and a support group for eating disordered students.
- Medical and legal resources for student survivors of sexual assault through contacts with the local hospital, the rape crisis center, or the sexual assault unit of the local police department.

Still another innovation is related to increased accessibility of mental health providers on campus. Recognizing that students do not function on an ordinary, business hours schedule, counseling centers are having success meeting student needs by expanding hours of operation. Accessibility is further extended with a 24-hour, seven days/week emergency coverage system with a pager service and counseling center Web site with links that can provide psychoeducation to an unlimited number of students anytime anyone is interested. Examples of Web sites that include

relevant information about college student mental health issues are:

- Dr. Bob's Mental Health Links at the University of Chicago (www.uhs.bsd.uchicago.edu/~bhsiung/mental.html).
- Counseling Center Village at the University of Buffalo, with links to university and college counseling center Web sites worldwide, self-help Web pages, and a virtual pamphlet collection (www.ub-counseling.buffalo.edu/ccv.html).
- Self-help brochures at the University of Illinois at Urbana-Champaign (www.couns.uiuc.edu/brochure.htm).

Clearly, computer technology accounts for a large proportion of the recent innovations in college counseling. Computer list-serves, such as the directors' list-serve of the Association of University and College Counseling Center Directors (AUCCCD), are an example of computer-based innovations. Davis and Humphrey (2000) point out various forms of high-technology communications that have the potential to extend counseling service delivery itself if counselors adopt them (e.g., chat rooms, bulletin boards, Web sites, e-mail, Web counseling, and simultaneous audio and video transmission).

RESOURCES FOR COLLEGE COUNSELORS

How can college counselors keep up with developments in the field of college mental health? As is true with all professions, the professional associations and related journals are excellent sources of information. Organizations worth joining include the American Psychological Association (APA), the American Counseling Association (ACA), and the American College Health Association (ACHA). Of specific interest in APA is Division 17, which is devoted to the field of Counseling Psychology, clearly the most directly related professional training program for doctoral-level college counselors. *The Counseling Psychologist* is published by Division 17 of APA. Affiliated with ACA is the American College Counseling Association (ACCA). The *Journal of College Counseling* is published by ACCA. The *Journal of American College Health* is published by the ACHA. Other journals related to the work of college counselors include *Journal of College Student Development, Journal of College Student Psychotherapy,* and *Journal of College Mental Health.*

SUMMARY

These are challenging times for college and university counseling centers. The current trend demands that competent and professional services be rendered on a wide range of mental health issues, for a more clinically demanding population, in ways that effectively reach a diverse group of students with increased accountability and fewer resources. Fortunately, standards, guidelines, and a wide variety of tools exist to help us with this task. Many of these resources have been addressed in this chapter. Standards such as those published by CAS and IACS help us to define our roles and functions clinically and administratively. Competency requirements, professional ethics, and common practices guide us toward the appropriate application of our trade. Tools made available through administrative innovation, accountability measures, professional affiliations, and improved communication and computer technology help us to serve our campus communities more effectively and efficiently. With sufficient awareness of these resources, and by working cooperatively, we can meet the challenges of today and realize our goals for tomorrow.

References

Altschuler, G.C. (2000, August 6). Adapting to college life in an era of heightened stress. *New York Times,* pp. 12, 16.

Amada, G. (1994). *Coping with the disruptive college student: A practical model.* Asheville, NC: College Administration Publications.

Archer, J., & Cooper, S. (1998). *Counseling and mental health services on campus: A handbook of contemporary practices and challenges.* San Francisco: Jossey-Bass.

Bishop, J.B. (1991). Managing demands on counseling services: A process of change (A response to Dworkin and Lyddon). *Journal of Counseling and Development, 69,* 408–410.

Bishop, J.B. (1995). Emerging administrative strategies for college and university counseling centers. *Journal of Counseling and Development, 74,* 33–38.

Chandler, L.A., & Gallagher, R.P. (1996). Developing a taxonomy for problems seen at a university counseling center. *Measurement and Evaluation in Counseling and Development, 29,* 4–12.

Council for the Advancement of Standards in Higher Education. (1997). *The CAS book of professional standards for higher education.* Washington, DC: Author.

Davis, D.C., & Humphrey, K.M. (Eds.). (2000). *College counseling: Issues and strategies for a new millennium.* Alexandria, VA: American Counseling Association.

Erickson Cornish, J.A., Riva, M.T., Henderson, M.C., Kominars, K.D., & McIntosh, S. (2000). Perceived distress in university counseling center clients across a six-year period. *Journal of College Student Development, 41,* 104–109.

Gallagher, P.J., & Demos, G.D. (1983). *Handbook of counseling in higher education.* New York: Praeger.

Gallagher, R.P., Gill, A.M., Goldstrohm, S.L., & Sysko, H.B. (1999). *National survey of counseling center directors.* Alexandria, VA: International Association of Counseling Services.

Gallagher, R.P., Gill, A.M., & Sysko, H.B. (2000). *National survey of counseling center directors.* Alexandria, VA: International Association of Counseling Services.

Guinee, J.P., & Ness, M.E. (2000). Counseling centers of the 1990's: Challenges and changes. *The Counseling Psychologist, 28,* 267–280.

Gilbert, S.P. (1992). Ethical issues in the treatment of severe psychopathology in University and college counseling centers. *Journal of Counseling and Development, 70,* 695–699.

Kiracofe, N.M., Donn, P.A., Grant, C.O., Podolnick, E.E., Bingham, R.P., Bolland, H.R., Carney, C.G., Clementson, J., Gallagher, R.P., Grosz, R.D., Handy, L., Hansche, J.H., Mack, J.K., Sanz, D., Walker, L.J., & Yamada, K.T. (1994). Accreditation standards for university and college counseling centers. *Journal of Counseling and Development, 73,* 38–43.

Kopta, S.M., & Lowry, J.L. (2000). *The Psychotherapy Outcome Assessment and Monitoring System: College counseling center version.* Unpublished manuscript.

Lambert, M.J., Hansen, N.B., Umphress, V., Lunnen, K., Okiishi, H., Burlingame, G.M., Heufner, J.C., & Reisinger, C.R. (1996). *Administration and Scoring manual for the Outcome Questionnaire (OQ-45.2).* Wilmington, DE: American Professional Credentialing Services LLC.

Mitchell, J.T., & Everly, G.S. (1993). *Critical incident stress debriefing (CISD): An operations manual for the prevention of traumatic stress among emergency services and disaster workers.* Elliott City, MD: Chevron Corporation.

O'Malley, K., Wheeler, I., Murphey, J., O'Connell, J., & Waldo, M. (1990). Changes in levels of psychopathology being treated at college and university counseling centers. *Journal of College Student Development, 31,* 464–465.

Pledge, D.S., Lapan, R.T., Heppner, P.P., Kivlighan, D., & Roehlke, H.J. (1998). Stability and severity of presenting problems at a university counseling center: A 6-year analysis. *Professional Psychology: Research and Practice, 29,* 386–389.

Sax, L.J., Astin, A.W., Korn, W.S., & Mahoney, K.M. (1999). *The American freshman: National norms for fall 1999.* Los Angeles: UCLA, Higher Education Research Institute.

Sharkin, B.S. (1997). Increasing severity of presenting problems in college counseling centers: A closer look. *Journal of Counseling and Development, 75,* 275–281.

Stone, G.L., & Archer, J., Jr. (1990). College and university counseling centers in the 1990's: Challenges and limits. *The Counseling Psychologist, 18,* 539–607.

Whiteley, S.M., Mahaffey, P.J., & Geer, C.A. (1987). The campus counseling center: A profile of staffing patterns and services. *Journal of College Student Personnel, 28,* 71–81.

World Health Organization International Consortium in Psychiatric Epidemiology. (2000). Cross-national comparisons of the prevalences and correlates of mental disorders. *Bulletin of the World Health Organization, 78,* 413–426.

5 DIVORCE COUNSELING

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Divorce rates in the United States reached historically high levels in the 1980s, making divorce a normative experience in American society (National Center for Health Statistics, 1995). Although the divorce rate showed a downward trend in the 1990s, at least 50% of recent marriages are expected to end in divorce (Cherlin, 1992), and about 60% of current divorces involve children (National Center for Health Statistics, 1995). The transition to divorce is often a significant stressor for both adults and children. Members of divorced families are two to three times as likely to receive psychological treatment compared to members of married families (Howard et al., 1996). Family members seek help both for dealing with psychological disorders, which are more common among children and parents in divorced families, but also for help in dealing with subclinical problems, such as painful feelings, unhappy memories, and ongoing distress associated with the family disruption (Emery, 1999).

Research shows that adults and children show a range of outcomes associated with the divorce transition. Among adults, anxiety, depression, alcohol abuse, loneliness, impulsivity, and emotional lability may emerge or increase in the aftermath of divorce (Bloom, Asher, & White, 1978; Hetherington, 1993). Separated and divorced adults, especially men, are also at increased risk for compromised immune system functioning and physical illness (Burman & Margolin, 1992; Dura & Kiecolt-Glaser, 1991). Compared to children from nondivorced families, children from divorced families are at higher risk for academic problems, externalizing and internalizing disorders, low social competence, low self-esteem, and problems in close relationships (Amato & Keith, 1991b). However, it should be noted that although the divorce transition is associated with significant distress for many, the normative outcome is resilience, with most children and adults eventually showing good psychological adjustment to the stressor of divorce (Emery, 1999).

It is probably most helpful to think of divorce as a process of life transitions rather than as a single event. Longitudinal research shows that much of the distress observed after divorce actually begins prior to divorce and can be attributed to the strains of unhappy marital and family relationships (Cherlin et al., 1991). The first two years following divorce are associated with significant distress and disruption in family life. By two years after divorce, however, most adults and children are adapting reasonably well (Hetherington, 1989). For both men and women, psychological well-being increases after the formation of a new mutually caring, intimate relationship, such as a successful remarriage (Hetherington, 1993). However, remarriage can present its own set of stressors when children are involved. The fact that divorce rates are even higher in remarriages than in first marriages means that many adults and children actually undergo multiple divorce-related transitions (Cherlin, 1992).

COUNSELING ADULTS DURING THE DIVORCE TRANSITION

Men and women going through divorce seek therapy at much higher rates than do married adults (Howard et al., 1996). These adults show a wide range of responses to divorce, including painful emotions of anger and sadness, feelings of guilt and remorse, and relief and excitement about the termination of a difficult marriage. Counseling can provide a safe place to express these feelings and to experience grief related to the multiple losses associated with the dissolution of a marriage. These include loss of a partner, loss of the dream of being happily married, and loss of roles, including one's role as spouse and as a member of the spouse's extended family. For many adults, divorce also involves significant changes in parent-child relationships and diminished contact with children, an especially important stressor for the noncustodial parent (Kitson, 1992). In some cases, parents who have difficulty accepting the reality of divorce will engage in drawn-out litigation as a way to maintain connection with the spouse (Emery, 1994). Counseling can assist these individuals to find more effective ways to deal with issues of loss and acceptance.

Counselors can provide an important element of social support during the divorce transition and can help the divorced adult problem-solve about ways to make use of other forms of support. Divorced adults commonly report social isolation and loneliness; in one study, 30% of divorced adults still experienced severe loneliness even 16 months after the divorce (Spanier & Thompson, 1983). Counseling can also address the multiple life changes that accompany divorce, which might include moving, establishing an independent household, and finding employment. These stressors are especially relevant for women, as the economic impact of divorce is significantly more negative for women than for men (McLanahan & Booth, 1989). Even small changes in coping strategies can be helpful in the face of these many stressors. One helpful resource for clients is Weiner-Davis's (1992) book *Divorce Busting*, which describes brief, solution-focused techniques for adults dealing with divorce-related distress.

Many divorcing adults seek help through support groups and group-based intervention programs. These programs typically involve 6 to 24 hours of group meetings and address topics such as finding a new support system, feelings of isolation and diminished self-esteem, running a household alone, financial planning, and dating (Lee, Picard, & Blain, 1994). These programs appear to be helpful in decreasing symptoms of depression and overall distress, with average improvement levels comparable to typical psychotherapy outcomes (Lee et al., 1994). Programs that have proven effective in improving participants' psychological adjustment and parenting skills include the Colorado Separation and Divorce Project (Hodges & Bloom, 1986), the Divorce Adjustment Project (Stolberg & Cullen, 1983), the Children of Divorce Parenting Intervention (Wolchik et al., 1993), and the Parenting through Change program (Forgatch & DeGarmo, 1999).

Many divorcing adults participate in short-term workshops designed to improve family functioning during the divorce transition. Although parents report high consumer satisfaction with these programs, research using control groups suggests little objective benefit either in terms of parenting or child functioning (Emery, Kitzmann, & Waldron, 1999). The strong interest in short-term programs, both on the part of community members and the court system, provides an opportunity for researchers to evaluate what works and what does not (Emery et al., 1999).

COUNSELING CHILDREN AFFECTED BY DIVORCE

The transition to divorce is one that affects all members of the family, and many children are referred for counseling during this difficult period. Children often have to cope simultaneously with painful emotions about their parents' divorce and with other transitions such as moving, changing schools, and making new friends. The child's ability to cope

with these stressors can be compromised by parents' expression of hostility toward one another, ongoing interparental conflict surrounding visitation or joint custody, or decreased or unpredictable contact with the noncustodial parent. Many children show problems during this transition, the most common being aggression and conduct problems (Amato & Keith, 1991b). Boys and girls appear to be equally affected, but may be differentially impacted by a parent's subsequent remarriage. For example, research in mother-custody families has shown that boys' problems tend to decrease with the addition of a stepfather, whereas this transition can entail new stressors for girls, who may have become closer to their mothers after the divorce (Hetherington, Bridges, & Insabella, 1998).

Developmental factors are critical in the discussion of counseling for children of divorce. Most children are younger than 6 when their parents divorce (Emery, 1999), and a great deal of the clinical literature focuses on the needs of these very young children. Among preschoolers from divorced homes, conduct problems are most prevalent (Amato & Keith, 1991b), and preschoolers also show significant confusion about being to blame for the divorce and about whether divorce means that a parent no longer loves them (Knoff & Bishop, 1997). In general, however, children in elementary and high school show more problems after divorce than do preschoolers or college students (Amato & Keith, 1991b). School-age children are more likely than younger children to try to mediate their parents' conflict, and although they may be better able to understand that divorce is not their fault, they may still feel responsible for fixing the problem (Knoff & Bishop, 1997). For adolescents, parental divorce may highlight struggles with the transition to young adulthood (Hodges, 1991). As adults, children of divorce are at higher risk for depression and life dissatisfaction (Amato & Keith, 1991a) and are much more likely than other adults to divorce themselves (Amato, 1996).

Individual counseling can provide a safe environment for the child to grieve the multiple losses inherent to divorce, express both love for and anger toward both parents, discuss misconceptions about the cause of divorce and who is to blame, and then begin to learn skills to overcome divorce-related fears and to cope with the divorce transition. Play therapy is commonly used with younger children, whereas older children and adolescents are more able to talk openly about their experiences related to their parents' divorce. Wallerstein (1989) has noted that regardless of the child's age, adaptation to divorce involves several psychological tasks. First, children must acknowledge the reality of the marital rupture and disengage from parental conflict and distress. With time, children resume a routine and customary activities and experience some resolution of their feelings of loss, self-blame, and anger. Finally, children must accept the permanence of the divorce and achieve realistic hopes about relationships.

Counselors can play an important role in encouraging parents to talk honestly with their children about the divorce at a level appropriate for the child's age. Parents can assure their children that they are not to blame and are not responsible for helping the parents to get along. At the same time, parents should be encouraged not to discuss with their children topics that are more appropriately discussed with other adults, such as feelings of hostility toward the ex-spouse, conflict over visitation or joint custody arrangements, and insecurities about finances. Parents can be helped to make the child's life as stable and consistent as possible, both within the custodial household and between households in cases of frequent visitation or joint custody. Books that may be helpful to parents include *Mom's House, Dad's House: A Complete Guide for Parents Who Are Separated, Divorced, or Remarried* (Ricci, 1997), *How It Feels When Parents Divorce* (Krementz, 1999), *Don't Divorce Us! Kids' Advice to Divorcing Parents* (Sommers-Flanagan, Elander, & Sommers-Flanagan, 1999), and *Dinosaurs Divorce: A Guide for Changing Families* (Brown & Krasny, 1999).

In addition to individual counseling, school-based group therapy programs are a common intervention for children of divorce.

Groups typically meet for 6 to 16 weeks and are designed to lessen children's isolation and loneliness, foster support and trust, and clarify misconceptions about divorce. As a whole, these groups show considerably lower effectiveness than psychotherapy in general (Lee et al., 1994). Two exceptions are the Children of Divorce Intervention Project, a 12-week intervention for children from kindergarten through sixth grade (Pedro-Carroll & Cowen, 1985), and the Divorce Adjustment Project, a 12- to 14-week program for children age 7 to 13 (Stolberg & Mahler, 1994).

COUNSELING COUPLES AND FAMILIES AFFECTED BY DIVORCE

Although most divorce-related counseling targets individual adjustment, interventions with two or more family members can also be helpful during the transition to divorce. Child custody mediation is an increasingly common alternative to litigation that many hope can act as a preventive intervention by improving coparenting and minimizing children's exposure to poorly resolved conflict (Emery & Wyer, 1987). Mediation is associated with faster resolution and fewer court hearings (Emery, 1994), higher participant satisfaction (Emery, Matthews, & Kitzmann, 1994), and increased compliance with child support agreements as well as greater involvement by noncustodial fathers in their children's lives (Dillon & Emery, 1996). However, mediation has not been shown to be associated with any mental health benefits, either for parents or children (Emery et al., 1994; Kitzmann & Emery, 1994).

Family therapy is another resource that may be helpful during divorce-related transitions. Although parents may be divorced and living apart, they may still meet regularly with their children in family therapy, especially in cases of joint physical custody or frequent visitation (Isaacs, Montalvo, & Abelsohn, 1986). Family therapy can help parents learn to shelter their children from poorly resolved interparental conflict and to provide consistent expectations and rewards in the two households, and can help maintain and strengthen children's relationships with both parents. Family therapy may also be helpful during the transition to remarriage and stepparenting, a period in which family roles and rules can be in flux (Crosbie-Burnett & Ahrons, 1985; Visher & Visher, 1988).

SUMMARY

Members of divorced families are two to three times as likely as members of married families to receive psychological treatment (Howard et al., 1996). Common interventions during the transition to divorce include individual therapy for adults and for children, support groups for adults, school-based intervention programs for children, mediation for couples, and family therapy.

Several points should be highlighted. First, little research has been conducted on the effectiveness of individual counseling for adults or children affected by divorce, or of family therapy for divorced and remarried families. Whereas group-based interventions for divorced adults have been found to be about as effective as individual therapy for improving psychological adjustment (Lee et al., 1994), most "weekend workshop" programs have not proven effective. With some high-quality exceptions, most school-based programs for children also show limited effectiveness. Mediation, although beneficial in several respects, is not associated with significant improvement in family members' mental health and is not a substitute for traditional forms of intervention.

Second, it is most helpful to think of divorce not as a single event, but as a process of transitions. Longitudinal research suggests that many of the problems thought to be caused by divorce are actually present well before the divorce occurs. After divorce, the first two years are the most stressful, but most adults and children show great improvement by two years. Several years after the divorce, however, many divorced adults remarry, a transition that can bring both benefits and additional stressors. Because the divorce rate

is even higher in second marriages than in first marriages, many adults and children are actually going through multiple transitions over the course of several years.

Finally, although the risk for psychological problems and involvement in therapy are both significantly higher in divorced families, most adults and children affected by divorce can be described as resilient, as most do not show mental health problems and most do not seek therapy (Emery et al., 1999). This is not to say that divorce has no impact, as many people affected by divorce report significant painful emotions, even years afterwards (Laumann-Billings & Emery, 2000). However, it would be a mistake to conclude that divorce by itself is the sole cause of the adjustment problems seen in adults and children from divorced families, as members of nondivorced high-conflict families have psychological problems comparable to those seen in families of divorce (Amato,1999). It is most helpful to view clients' problems as a response to multiple stressors, including marital conflict and problematic family relationships.

References

Amato, K. (1996). Explaining the intergenerational transmission of divorce. *Journal of Marriage and the Family, 58,* 628–640.

Amato, K. (1999). Children of divorced parents as young adults. In E.M. Hetherington (Ed.), *Coping with divorce, single parenting, and remarriage* (pp. 147–163). Mahwah, NJ: Erlbaum.

Amato, K., & Keith, B. (1991a). Parental divorce and adult well-being: A meta-analysis. *Journal of Marriage and the Family, 53,* 43–58.

Amato, K., & Keith, B. (1991b). Parental divorce and the well-being of children: A meta-analysis. *Psychological Bulletin, 110,* 26–46.

Bloom, B.L., Asher, S.J., & White, S.W. (1978). Marital disruption as a stressor: A review and analysis. *Psychological Bulletin, 85,* 867–894.

Brown, M.T., & Krasny, L. (1999). *Dinosaurs divorce: A guide for changing families* (2nd ed.). New York: Little, Brown.

Burman, B., & Margolin, G. (1992). Analysis of the association between marital relationships and health problems: An interactional perspective. *Psychological Bulletin, 112,* 39–63.

Cherlin, A. (1992). *Marriage, divorce, remarriage.* Cambridge, MA: Harvard University Press.

Cherlin, A., Furstenberg, F.F., Chase-Lansdale, P.L., Kiernan, K.E., Robins, P.K., Morrison, D.R., & Teitler, J.O. (1991). Longitudinal studies of effects of divorce in children in Great Britain and the United States. *Science, 252,* 1386–1389.

Crosbie-Burnett, M., & Ahrons, C.R. (1985). From divorce to remarriage: Implications for therapy with families in transition. *Journal of Psychotherapy and the Family, 1,* 121–137.

Dillon, P., & Emery, R.E. (1996). Divorce mediation and resolution of child custody disputes: Long-term effects. *American Journal of Orthopsychiatry, 66,* 131–140.

Dura, J.R., & Kiecolt-Glaser, J.K. (1991). Family transitions, stress, and health. In P.A. Cowan & E.M. Hetherington (Eds.), *Family transitions* (pp. 59–76). Hillsdale, NJ: Erlbaum.

Emery, R.E. (1994). *Renegotiating family relationships: Divorce, child custody, and mediation.* New York: Guilford Press.

Emery, R.E. (1999). *Marriage, divorce, and children's adjustment* (2nd ed.). Newbury Park, CA: Sage.

Emery, R.E., Kitzmann, K.M., & Waldron, M. (1999). Psychological interventions for separated and divorced families. In E.M. Hetherington (Ed.), *Coping with divorce, single parenting, and remarriage* (pp. 323–344). Hillsdale, NJ: Erlbaum.

Emery, R.E., Matthews, S., & Kitzmann, K.M. (1994). Child custody mediation and litigation: Parents' satisfaction and functioning a year after settlement. *Journal of Consulting and Clinical Psychology, 62,* 124–129.

Emery, R.E., & Wyer, M.M. (1987). Divorce mediation. *American Psychologist, 42,* 472–480.

Forgatch, M.S., & DeGarmo, D.S. (1999). Parenting through change: An effective prevention program for single mothers. *Journal of Consulting and Clinical Psychology, 67,* 711–724.

Hetherington, E.M. (1989). Coping with family transitions: Winners, losers, and survivors. *Child Development, 60,* 1–14.

Hetherington, E.M. (1993). An overview of the Virginia Longitudinal Study of Divorce and Remarriage with a focus on early adolescence. *Journal of Family Psychology, 7,* 39–56.

Hetherington, E.M., Bridges, M., & Insabella, G.M. (1998). What matters? What does not? Five perspectives on the association between marital transitions and children's adjustment. *American Psychologist, 53,* 167–184.

Hodges, W., & Bloom, B. (1986). Preventive intervention program for newly separated adults: One year later. *Journal of Preventive Psychiatry, 3,* 35–49.

Hodges, W.F. (1991). *Interventions for children of divorce: Custody, access, and psychotherapy* (2nd ed.). New York: Wiley.

Howard, K.I., Cornille, T.A., Lyons, J.S., Vessey, J.T., Lueger, R.J., & Saunders, S.M. (1996). Patterns of service utilization. *Archives of General Psychiatry, 53,* 696–703.

Isaacs, M.B., Montalvo, B., & Abelsohn, D. (1986). *The difficult divorce.* New York: Basic Books.

Kitson, G.C. (1992). *Portrait of divorce.* New York: Guilford Press.

Kitzmann, K.M., & Emery, R.E. (1994). Child and family coping one year after mediated and litigated child custody disputes. *Journal of Family Psychology, 8,* 150–157.

Knoff, H.M., & Bishop, M.D. (1997). Divorce. In G.G. Bear, K.M. Minke, & A. Thomas (Eds.), *Children's needs: II. Development, problems, and alternatives* (pp. 593–604). Bethesda, MD: National Association of School Psychologists.

Krementz, J. (1999). *How it feels when parents divorce.* New York: Knopf.

Laumann-Billings, L., & Emery, R.E. (2000). Distress among young adults from divorced families. *Journal of Family Psychology, 14,* 671–687.

Lee, C., Picard, M., & Blain, M. (1994). A methodological and substantive review of intervention outcome studies for families undergoing divorce. *Journal of Family Psychology, 8,* 3–15.

McLanahan, S., & Booth, K. (1989). Mother-only families: Problems, prospects, and politics. *Journal of Marriage and the Family, 51,* 557–580.

National Center for Health Statistics. (1995). Advance report of final divorce statistics 1989 and 1990: Supplement. *Monthly Vital Statistics Report, 43*(9). Hyattsville, MD: Author.

Pedro-Carroll, J.L., & Cowen, E.L. (1985). The Children Cope with Divorce program: An investigation of the efficacy of a school-based prevention program. *Journal of Consulting and Clinical Psychology, 53,* 603–611.

Ricci, I. (1997). *Mom's house, dad's house: A complete guide for parents who are separated, divorced, or remarried* (2nd ed.). New York: Simon & Schuster.

Sommers-Flanagan, R., Elander, C., & Sommers-Flanagan, J. (1999). *Don't divorce us! Kids' advice to divorcing parents.* Alexandria, VA: American Counseling Association.

Spanier, G.B., & Thompson, L. (1983). Relief and distress after marital separation. *Journal of Divorce, 7,* 31–49.

Stolberg, A., & Cullen, P. (1983). Preventive interventions for families of divorce: The Divorce Adjustment Project. In L.A. Kurdek (Ed.), *New directions in child development: Children and divorce* (Vol. 19, pp. 71–81). San Francisco: Jossey-Bass.

Stolberg, A., & Mahler, J. (1994). Enhancing treatment gains in a school-based intervention for children of divorce through skill training, parental involvement, and transfer procedures. *Journal of Consulting and Clinical Psychology, 62,* 147–156.

Visher, E., & Visher, J. (1988). *Old loyalties, new ties: Therapeutic strategies with stepfamilies.* New York: Brunner/Mazel.

Wallerstein, J.S. (1989). *Second chances: Men, women, and children a decade after divorce.* New York: Ticknor and Fields.

Weiner-Davis, M. (1992). *Divorce-busting.* New York: Summit Books.

Wolchik, S.A., West, S.G., Westover, S., Sandler, I.N., Martin, A., Lustig, J., Tein, J., & Fisher, J. (1993). The Children of Divorce parenting intervention: Outcomes evaluation of an empirically based program. *American Journal of Community Psychology, 21,* 293–331.

6 DEATH AND BEREAVEMENT

Stephen J. Freeman

Those in the counseling profession often have as their guiding light, and rightly so, the idea that counseling and therapy should instill hope. In light of this view, there may be a hesitancy to venture into the perceived hope-defeating realm of death and bereavement. The question arises, Why study such topics? The answer is simple: Death is a natural part of life and bereavement is an inescapable concomitant part of that life and of our natural inclination to relate to and bond with others.

A death loss is a disruption in the attachment bond a person has with a significant other in his or her environment. As such, the system must reorganize to a different level. The self is a system whose task is to regulate behavior designed to maintain contact with a significant other. The goal of the system is to maintain comfort and security through connectedness. This reorganization process generally follows four phases (Bowlby, 1980):

> *Phase I:* Phase of numbing. This phase is characterized by an initial disbelief that the death has actually occurred and usually lasts from a few hours to a week and may be interrupted by outbursts of extreme emotion.
>
> *Phase II:* Phase of yearning and searching. Survivors may be restless, preoccupied with thoughts of the deceased, and prone to initially interpret events (phone ringing, door opening) as coming from the deceased person.
>
> *Phase III:* Phase of disorganization and despair. It will become apparent that attachment behaviors that were effective in maintaining the attachment bond while the deceased was alive are no longer working. The person begins to wonder if any part of prior life is salvageable. This can create despair. The self without the deceased person must be reevaluated and redefined, requiring full acceptance of the loss.
>
> *Phase IV:* Phase of greater or lesser degree of reorganization. Now that the bereaved individual has come to a realization that life must go on, various changes may begin to take place. Thoughts of the deceased begin to take a different place in the bereaved's life. Social relationships and responsibilities may also be changing to accommodate a world without the person who was lost. (p. 85)

THE GRIEF EXPERIENCE

In addition to Bowlby's phases, Westberg (1962) lists ten fairly common stages for people in grief. These are described below. It should be understood, however, that grief is fluid and most people do not begin with stage 1 and proceed in an orderly fashion to stage 10. There is a great deal of movement among and within the stages, and often, bereaved individuals will comment that after a week or two of "progress," they have reverted back to the beginning. It is important to remember that grief contains the emotional illusion of regression when, in fact, movement is always forward. At worst, one is merely standing

still. As long as the grieving process is not diluted or interrupted, there is progress:

1. *Shock.* The shock of death is to be expected even after a long illness and months of anticipatory grief. People often describe the first few weeks of grief as having been on autopilot. There is little actual memory of specific details, merely the knowledge that one did what had to be done. Shock usually wears off after five or six weeks, but may last much longer, depending on the person's skill at self-protection from painful feelings and the significance of the relationship.
2. *Emotional Release.* It is not uncommon to see intense emotional release at the time of the death, and then have it seem to dry up for a number of weeks. When the shock finally dissipates, the bereaved will often feel strong emotions such as anger, fear, remorse, and extreme loneliness. Lives are reviewed during this period, and people are amazed to discover the degree of dependence they felt for the person who died. This can lead to loss of self-esteem and feelings of inadequacy.
3. *Depression.* Depression takes the emotions mentioned above and intensifies them, adding feelings of helplessness and hopelessness. The bereaved will complain of not feeling their loved one close to them anymore, of wanting to be with him or her. There are fears of suicide from friends and family, but the bereaved will usually express it as "I won't do anything to myself, but if death comes for me tonight, I won't fight it."
4. *Physical Symptoms of Distress.* This is a very common phenomenon, especially in children. If the deceased died of a heart attack, the survivor(s) may experience tightness in the chest, pain radiating to the jaw and down the left arm, and other symptoms associated with a heart attack.
5. *Anxiety.* The bereaved experience vivid dreams, waking and sleeping, in which they see or hear their loved one. There is also spiritual anxiety, expressed as "Where is my loved one now? Is he or she happy? How can he or she be at peace knowing I am suffering so much?" There is also the fear that the anger being felt toward God will bring about punishment in the form of additional losses. Many experience deep anxiety over the possibilities of forgetting their loved one and will express concern that they can no longer recall how the person smiled or how his or her voice sounded.
6. *Hostility.* Anger usually surfaces in the sixth or eighth week after death. This rage is sometimes random, sometimes specific. God, medical professionals, clergy, and the deceased are frequent targets. Usually, the individual is confused by the intensity of the anger, seeing it as inappropriate but feeling unable to defuse it.
7. *Guilt.* Guilt is sometimes real, often imaginary or exaggerated, but should always be taken with great seriousness. Death amplifies whatever problems existed in the relationship, and even minor life issues that had been virtually ignored are now insurmountable obstacles for the survivor. The "shoulds" seem to rule the world of the bereaved: "I should have done this. I should not have done that." Rational explanations may soothe for a time, but usually the guilt will return until resolution is achieved. No one can punish us better that we can punish ourselves, and the instrument is guilt.
8. *Fear.* Fear wears many faces with the bereaved. There may be a fear of sleeping in the same bed or room. There may be a fear of leaving the house or of staying in it. People are afraid of the aloneness that comes after a death, and they are also afraid of beginning new relationships, however platonic these may be. There is a fear of never knowing joy again or not being able to laugh without guilt. The act of living becomes fearful for the person who feels so lost without his or her loved one, and each day is a burden to be endured.
9. *Healing through Memories.* The bereaved move back and forth between good memories and bad. At times, it seems that there is a need for self-punishment, and so all the negative aspects of the relationship are

resurrected and relived. The happier moments often seem too painful, and it may take many months before these can be faced, but there is healing in remembering. As the memories become less painful, there is an ability to begin to face the world once again.

10. *Acceptance.* There is a difference between accepting the reality of death (thereby letting go) and forgetting the person who has died. As with the healing of any serious wound, there will always be a scar to remind one of the injury. With time will come a lessening of the pain, until finally the injury can be touched, remembered, and accepted as a new part of the life being lived. This acceptance may take two years or more to achieve, depending on the depth of emotional investment one made in the relationship with the deceased.

Within these phases and stages, there is a continuum of behaviors ranging from normal and healthy to dysfunctional for the person who is grieving. Westberg's (1962) theory suggests that the patterns of loss following a death are similar (but not identical in duration or intensity) regardless of age, gender, or relationship to the deceased.

THE NORMAL EXPERIENCE OF GRIEF: FACILITATING GRIEF COUNSELING

A helpful concept for both the mourner and the caregiver is the tasks of mourning. The mourner's awareness of these needs or tasks of grief work can give a participative, action-oriented outlook to the experience of grief as opposed to a perception of grief being a phenomenon experienced in a passive manner. This also provides a framework for outlining a significant portion of the helper's role.

Tasks of Mourning

The first task of mourning is to experience and express outside of oneself the reality of the death (Lindemann, 1944; Parks & Weiss, 1983; Worden, 1991). This involves confronting the reality that the person has died and will not be coming back. Questions to ask yourself as a counselor working with the bereaved:

> Where is the person in terms of confronting the reality that his or her loved one has died?
>
> Do I need to respect the person's need to avoid the full reality of the loss for a period of time while attempting to help him or her cautiously confront this new reality?
>
> Is the person using unhealthy defense mechanisms such as overuse of alcohol, overeating, the traveling cure, or similar behaviors?

The second task of mourning is to tolerate the emotional suffering that is inherent in the grief while nurturing oneself both physically and emotionally (Parks & Weiss, 1983; Shuchter & Zisook, 1990; Worden, 1991). The thoughts and feelings (pain of grief) resulting from this encounter with death must be absorbed. If avoided or denied, the movement toward resolution is inhibited. Questions to ask yourself as a counselor working with the bereaved:

> Has the person allowed himself or herself to experience the pain of grief? If so, with whom has he or she shared their grief?
>
> Was the person provided with a sense of feeling understood in the expression of his or her grief?

The third requisite of mourning is to convert the relationship with the deceased from one of presence to one of memory (Lindemann, 1944; Parks & Weiss, 1983; Rando, 1987, 1993; Ruskay, 1996; Sable, 1991; Worden, 1991). The mourner works to modify and detach the emotional ties to the person who has died in preparation to live in an altered relationship with the dead person. The mourner should not be expected to relinquish all ties to the person who died. However, an alteration of the relationship must be accomplished. Accomplishing an evolution of this type often provides a sense of meaning to the bereaved. Questions

to ask yourself as a counselor working with the bereaved:

Where is the person in the process of converting the relationship from one of presence to one of memory?

Is the bereaved resisting any change in viewing the relationship as one of presence? If so, what contributing factors may be influencing this (e.g., nature of the relationship with the deceased, personality of the deceased or of the bereaved)?

Does the bereaved think he or she must give up all forms of bonding with the deceased?

What can I do as a counselor to help facilitate a new type of relationship rooted in memory (e.g., stimulation of memories, new rituals, expression of dreams)?

The fourth task of mourning is to develop a new sense of self-identity based on a life without the deceased (Lindemann, 1944; Parks & Weiss, 1983; Ruskay, 1996; Worden, 1991). Role confusion involves the struggle between the *we* and the *I* and fears associated with one's new autonomy. Research suggests that women have more difficulty in this struggle than men; however, women are much more likely than men to seek support and guidance as they struggle with the development of this new identity.

Questions to ask yourself as a counselor working with the bereaved:

Where is the bereaved in the process of forming a new self-identity?

Is time a factor influencing where this person is currently?

What are the role changes that this person is experiencing?

Are role models of persons who have gone through similar experiences available to the bereaved?

To complete the grief work, one must relate the experience of loss to a context of meaning. The bereaved will typically question their philosophy of life, their values in seeking an answer to the question "Why?" As Nietzsche (1968) said, "It was not the suffering that was his problem but that the question was wanting to the outcry, Why the *suffering*?"

Questions to ask yourself as a counselor working with the bereaved:

Where is the person in the process of relating the experience of loss to a context of meaning?

What were the person's religious and philosophical beliefs about life before the loss?

How has the loss altered these beliefs?

What is standing between the bereaved and their accepting their fate?

TIME INTERVALS AND IMPLICATIONS FOR COUNSELORS

The time guide for counselors is as fluid as the stages of grief. People move within the stages quickly, sometimes going back to the first hours and then jumping well ahead of where they actually are, feeling as though they have finally finished. This is normal and to be expected. The following is only a descriptive guide (Freeman & Ward, 1998).

First 48 hours. The shock of the death can be intense, and denial is often strong in the first hours. The emotional response can be frightening to the bereaved and friends and family members.

First week. The necessity of planning the funeral and making other arrangements usually takes over, and the bereaved may function in an automatic manner. This may be followed by a feeling of letdown and emotional and physical exhaustion.

2 to 5 weeks. There is a general feeling of abandonment as family and friends return to their own lives after the funeral. Employers often expect the bereaved to have recovered and to be fully functional on the job. The insulation of shock may still be in effect, and there may be a sensation of "This isn't going to be as bad as I first thought."

6 to 12 weeks. It is during this time that the shock finally wears off and the reality of the loss sets in. Emotions range widely, and the person feels out of control and lack support of family or friends, who may think, "That was three months ago. Why are you feeling bad now?" Some of the experiences during this time are:

- Radical changes in sleep patterns.
- Onset of fear, sometimes paranoia.
- Changes in appetite with significant weight gain or loss.
- Changes in libido.
- Periods of uncontrollable weeping.
- Loss of motivation.
- Fatigue and generalized weakness.
- Physical symptoms of distress.
- Muscle tremors.
- Increased need to talk about the deceased.
- Extreme mood swings.
- Desire for isolation.
- Inability to concentrate or remember.

3 to 4 months. The cycle of good and bad days begins. Irritability increases and there is a lowering of frustration tolerance. There may be verbal and physical acting out of anger, feelings of emotional regression, and an increase in somatic complaints, especially flu and colds, as the immune system is depressed.

6 months. Depression sets in as the sixth-month anniversary approaches. The event of loss is relived and the emotional upheaval seems to be starting all over again. Anniversaries, birthdays, and holidays are especially difficult, bringing about renewed depression.

12 months. The first anniversary of the death can be traumatic or the beginning of resolution, depending on the amount and quality of grief work done during the year.

18 to 24 months. This is the time for resolution. The pain of separation becomes bearable, and the bereaved is able to proceed with the living of their own life. There is an emotional letting go of the deceased, a recognition that, although the person will never be forgotten, the pain of the death will no longer need to be the focal point of the life of the bereaved. It is during this phase that the terms bereaved and grieving are eased from the vocabulary, and the process of living begins in earnest.

Bowlby (1980) suggests that clinicians sometimes have unrealistic expectations about the progress people should be making as they grieve. He quotes one widow: "Mourning never ends: only as time goes on it erupts less frequently" (p. 101). Rando (1983) describes a V configuration, with bereavement intensity decreasing in the second year and increasing in the third year. This suggests that patterns of grieving fluctuate over time in a nonlinear fashion (Gray, 1987). Grief and mourning are uniquely individual processes and no one has the correct timetable for their completion.

PATHOLOGICAL GRIEVING: ABNORMAL GRIEF RESPONSE

Pathological or abnormal grief is the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behavior, or remains interminably in the state of grief without progression of the mourning process toward completion. It involves processes that do not move progressively toward assimilation or accommodation but, instead, lead to stereotyped repetitions or extensive interruptions of healing (Horowitz, Wilmer, Marmar, & Krupnick, 1980, p. 1157).

Research (de Vries, 1997; Grad & Zavasnik, 1996; Horowitz et al., 1980; Rubin & Schechter, 1997; Worden, 1991) suggests that complicated bereavement has to do with four primary factors: relational, circumstantial, historical, and personality factors.

Relational Factors

Relational factors define the type of relationship the person had with the deceased. The most frequent type of relationship that hinders people from adequate grieving is one

involving extreme ambivalence coupled with unexpressed hostility. Highly narcissistic relationships, in which the deceased represents an extension of the bereaved, necessitate confronting a loss of part of oneself, thus making for complications. Highly dependent relationships are also difficult to grieve. In this type of relationship, the bereaved loses the source of strength that has sustained them, and the result is an overwhelming sense of abandonment and helplessness. The sense of overwhelming helplessness and loss of self-concept tend to overwhelm any other feelings, including feelings related to healthy grief.

Circumstantial Factors

Circumstances surrounding a loss may preclude or make completion of the grieving process difficult or impossible. Uncertainty of the loss, not knowing if a person is truly dead, precludes adequate grieving (e.g., missing children, soldier who is listed MIA, or disaster victims whose bodies are not recovered). Where no concrete evidence of death is found, mourning can be unresolved. Situations where multiple losses occur (e.g., Oklahoma City bombing) can make grieving nearly impossible due to the sheer volume involved. Where there are multiple losses in close proximity, it becomes easier to shut down completely.

Historical Factors

Individual history involving prior experience of complicated grief results in a higher probability of having complications again. Additionally, past losses and separations have an affect on current losses and separations and the capacity for future attachments. History of mental illness can predispose one to complications that prevent adequate grief response.

Personality Factors

Grief resolution requires the experiencing of universal feelings of helplessness in the face of existential loss; personality factors are related to how well or poorly a person copes with emotional distress. Inability to tolerate extreme emotional distress leads to defensive withdrawal and can short-circuit the grieving process.

SUMMARY

When an attachment bond is broken, people experience a grief response. A loss through death is a normal and universal phenomenon that requires everyone who experiences it to reevaluate and reorganize their attachments to significant others. Bowlby (1980) posited that reorganization of attachment progresses through four phases. Reorganization and resolution of the grieving process require time for successful completion of the tasks of mourning.

References

Bowlby, J. (1980). *Loss, sadness and depression.* New York: Basic Books.

de Vries, B. (1997). Kinship bereavement in later life: Understanding the variations in cause, course, and consequence. *Omega: Journal of Death and Dying, 35,* 141–157.

Freeman, S., & Ward, S. (1998). Death and bereavement: What counselors should know. *Journal of Mental Health Counseling, 20*(3), 216–226.

Grad, O., & Zavasnik, A. (1996). Similarities and differences in the process of bereavement after suicide and after traffic fatalities in Slovenia. *Omega: Journal of Death and Dying, 33,* 243–251.

Gray, R. (1987). Adolescent response to the death of a parent. *Journal of Youth and Adolescence, 16*(6), 511–525.

Horowitz, M., Wilmer, N., Marmar, C., & Krupnick, J. (1980). Pathological grief and the activation of latent self-images. *American Journal of Psychiatry, 137,* 1157–1162.

Lindemann, E. (1944). Symptomology and management of acute grief. *American Journal of Psychiatry, 101,* 141–148.

Nietzsche, F. (1967). *The genealogy of morals and ecco homo* (Walter Kaufmann, Trans.). New York: Vintage Books.

Parks, C., & Weiss, R. (1983). *Recovery from bereavement.* New York: Basic Books.

Rando, T.A. (1983). An investigation of grief and adaptation in parents whose children have died from cancer. *Journal of Pediatric Psychology, 8*(1), 3–20.

Rando, T.A. (1987). The unrecognized impact of sudden death in terminal illness and in positively progressing convalescence. *Israeli Journal of Psychiatry and Related Sciences, 24*(1/2), 125–135.

Rubin, S., & Schechter, N. (1997). Exploring the social constructs of bereavement: Perceptions of adjustment and recovery in bereaved men. *American Journal of Orthopsychiatry, 67,* 279–289.

Ruskay, S. (1996). Saying hello again: A new approach to bereavement counseling. *Hospice Journal, 11,* 5–14.

Sable, P. (1991). Attachment, loss of spouse, and grief in elderly adults. *Omega: Journal of Death and Dying, 23*(2), 129–142.

Shuchter, S.R., & Zisook, S. (1990). Hovering over the bereaved. *Psychiatric Annals, 20*(6), 327–333.

Westberg, G. (1962). *Goodgrief.* Philadephia: Fortress Press.

Worden, J.W. (1991). *Grief counseling and grief therapy.* New York: Springer.

7 STRESS, COPING, AND WELL-BEING

Applications of Theory to Practice

John L. Romano

Stress, coping, and well-being are three constructs that have received much attention in the psychological literature and mass media markets. The concepts are applicable to children and adolescents, as well as adults. In this chapter, I present an overview of how each of these terms has been conceptualized. The overview is followed by a conceptual framework describing how psychological practitioners may interact with clients to help them reduce stress, strengthen coping strategies, and promote overall well-being.

STRESS

Although the layperson may have a general understanding of the meaning of stress, stress has been conceptualized and defined differently by scholars. Physiologist Hans Selye (1976) defined stress as the "nonspecific response of the body to any demand" (p. 1). Selye's work followed in the tradition of two other physiologists, Claude Bernard and Walter Cannon, who studied the ability of living organisms to maintain internal physiological constancy despite changes in their external environments. Cannon (1932) referred to this internal balance as homeostasis. The phrase "flight or fight," referring to responses to survive a dangerous situation, requires an adaptation of the organism to meet the danger, thus changing the organism's internal balance. Although the flight-or-fight response helps us to survive life-threatening situations (e.g., a pedestrian rapidly moving

away from an approaching vehicle), prolonged arousal that upsets internal physiological balance can lead to negative health consequences (Rice, 1999).

Physiological adaptation to stressful life events is the theoretical basis for the development of the popular Social Readjustment Rating Scale (SRRS; Holmes & Rahe, 1967). This scale is made up of 43 life events ranked in order of degree of personal difficulty, from 1 ("death of a spouse") to 43 ("minor violations of the law"). Holmes and Rahe hypothesized that the onset of physical illness was associated with the number and severity of life events. The life events conceptual framework and variations of life event scales have been developed for other populations, including children and adolescents (Coddington, 1972; Masten, Neemann, & Andenas, 1994) and college students (Marx, Garrity, & Bowers, 1975). Although the Holmes and Rahe research brought attention to life events, physiological adaptation, and their impact on health, the research has been criticized for yielding low correlations between life events and illness (Dohrenwend & Dohrenwend, 1984; Somerfield & McCrae, 2000). Sarafino (1998) summarized the literature highlighting other limitations of the SRRS, including the ambiguity of some of the items, variations in importance that people attach to the events, and the lack of consideration of contextual factors related to the life events and onset of illness. For example, financial reserves and job satisfaction will impact the significance of a job loss, and genetic factors may influence the onset of disease. Lazarus (1992) also argues that it is difficult to demonstrate psychosocial influences on health for some of these same reasons.

As a response to the early and almost exclusive attention to physiological changes that accompany stressful events, and also to account for individual differences, Lazarus and his colleagues (Lazarus & Folkman, 1984) present a transactional, cognitive model of stress. They conceptualize stress as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p. 19). A person's appraisal of the event and his or her ability to cope with the event are central to Lazarus's formulation. During a stressful encounter, a person makes "primary" and "secondary" appraisals of the situation. Primary appraisal refers to the amount of threat the person perceives, and secondary appraisal is the person's evaluation of his or her ability to cope with the threat. These appraisals are sometimes fleeting, and the person can reappraise a situation as new information is learned. Lazarus furthered our understanding of stress by considering both the person and the stressful event, whereas previous work focused primarily on either the person or the stressful event.

Stevan Hobfoll (1989), critical of Lazarus's conceptualization of stress for being circular and overly emphasizing perceptions, brought a different perspective to psychological stress. In his "conservation of resources" model, Hobfoll defined stress "as a reaction to the environment in which there is (a) the threat of a net loss of resources, (b) the net loss of resources, or (c) a lack of resource gain following the investment of resources" (p. 516). Therefore, stress occurs because of an actual or perceived loss of resources or lack of gain of resources following investment. Resources can include "objects, personal characteristics, conditions, or energies that are valued by the individual or that serve as a means for attainment of these objects, personal characteristics, conditions, or energies" (p. 516).

Rice (1999) has summarized other models of stress, including those based on learning, psychodynamic, and social theory. Although each theory of stress has limitations, collectively they offer different opportunities and options to intervene with clients who are experiencing stress reactions.

COPING

Closely aligned to the study of stress are conceptual models of how people cope with stress. The study of coping, as with stress, offers different theoretical approaches. Aldwin

(1994) placed the study of coping into three broad categories: person-, situation-, and cognitive-based approaches. Person-based approaches hypothesize that personality characteristics are major determinants of how people cope with stress. These approaches have their roots in psychoanalytic theory and the use of defense mechanisms to cope with stress. Situational approaches argue that coping behaviors are largely influenced by the contextual factors surrounding the stressor; people cope differently depending on the nature of the stressor. Cognitive approaches, exemplified by Lazarus's (1993) work, are based on the person's cognitive appraisal of the situation.

Lazarus (1993) defines coping "as ongoing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 237). According to Lazarus, coping behaviors can be problem-focused or emotion-focused. Problem-focused coping functions to alter the person-environment relationship to improve a stressful situation, whereas emotion-focused coping attempts to moderate the emotional distress associated with a stressful event. An example of the former is seeking legal advice during a marital separation; joining a support group during the separation would be an example of the latter. Obviously, as these examples show, problem- and emotion-focused coping are not mutually exclusive, and they are both utilized to cope with many stressful situations.

The research on stress and coping has grown exponentially during the past 30 years (Somerfield & McCrae, 2000). However, some have argued that much of the research offers little of practical value to clinicians (Coyne & Racioppo, 2000). Others are less pessimistic but acknowledge the necessity of bridging the gap between stress and coping research and clinical practice (Lazarus, 2000).

WELL-BEING

Psychology has been dominated by research and clinical practice focusing on negative affect, psychopathology, and remediation. In recent years, there has been a resurgence of interest and scholarly attention to positive affect, health and well-being, and prevention. Seligman and Csikszentmihalyi (2000), introducing a special issue of *American Psychologist,* describe positive psychology as "a science of positive subjective experience, positive individual traits, and positive institutions . . . to improve the quality of life" (p. 5). Lightsey (1996) presents an extensive literature review of subjective well-being and psychological resources and concludes by offering several recommendations for counselors (e.g., helping clients develop positive beliefs about themselves and teaching active problem-solving skills to mediate stress reactions). Romano (1997) conceptualized "student well-being" as "the development of knowledge, attitudes, skills, and behaviors that maximize students' functioning" (p. 246). A large body of literature has investigated competence, resiliency, and stress resistance in children (Garmezy, Masten, & Tellegen, 1984; Masten & Coatsworth, 1998; see also Rak, this volume). After reviewing the literature, Benard (1993) concluded that resilient children have four attributes: social competence, problem-solving skills, autonomy, and a sense of purpose. Folkman and Moskowitz Tedlie (2000) point out that negative affect and distress have dominated the stress and coping literature. They argue for greater attention to the study of positive affect and positive outcomes associated with stressful events. Romano and Hage (in press) strongly recommend that greater attention be given to the prevention of psychological disturbances and problematic lifestyle behaviors in the training and practice of psychologists and counselors.

FRAMEWORK TO HELP CLIENTS MANAGE STRESS, IMPROVE COPING, AND ENHANCE WELL-BEING

Mental health practitioners can be instrumental in helping clients reduce stress, improve coping, and strengthen overall well-being to

improve the client's psychological, occupational, and social functioning. The framework here presented is appropriate for individual and group work, as well as for preventive and remedial interventions.

Clients often seek counseling only after other alternatives to manage a stressor have been tried and found lacking (e.g., advice from family/friends, self-help books). Sometimes, the stressors are manifested in physical symptoms such as muscular pain, stomach distress, or headaches. When clients present physical symptoms, it is necessary for therapists to make a referral to a physician to eliminate organic causes for the symptoms. In other words, it should not be assumed that psychological stress is the primary cause of the physical symptoms. Excessive stress can also be manifested in sleep and eating disturbances, increased use of alcohol and other drugs (i.e., legal and illegal and over-the-counter and prescribed medications), and interpersonal difficulties at home and work. During initial sessions, counselors and psychologists need to assess how the client is currently coping with the stressful situation. This assessment should include questions about alcohol and drug use, episodes of depression, suicidal ideation, and incidences of violent behaviors. In addition, questions about sleep patterns, eating behavior, and physical activity should be asked.

The framework includes three components: (1) increase awareness of behaviors and reactions associated with a stressful situation, (2) improve coping strategies, and (3) strengthen well-being.

Increase Awareness

One goal of many preventive and remedial psychological interventions is to increase the participant's or client's personal awareness. When a presenting issue is stress-related, it is important that clients gain increased awareness of their personal responses to the stressful situation.

Physiological Awareness. Selye's (1976) contributions made us acutely aware of physiological changes that accompany stressful events. Because of these physiological reactions, it is important that mental health professionals help clients understand physical changes that may occur during stressful events. Therapists can explain the flight-or-fight response and the physiology of stress, including descriptions of the sympathetic and parasympathetic nervous systems and hormonal changes that occur during a stress response. Clients are usually aware of the physical reactions because they have experienced many of them, for example, muscle tension, rapid heartbeat, cold fingers, and shallow breathing. Greater understanding of the reasons for these changes helps clients reduce their fears about them and appreciate the value of coping interventions (e.g., relaxation training) designed to moderate the physical effects of stress. A related benefit is a greater sense of physiological control. Biofeedback therapy can help clients learn more subtle physiological information about themselves. In the absence of sophisticated biofeedback equipment (e.g., electromyograph), clients can be encouraged to be aware of physiological changes that accompany stressful situations (e.g., an excessively tight grip on a telephone during an important call).

Cognitive Awareness. Cognitive psychology has made us very aware of the role of private thoughts in emotional disturbance (Beck & Weishaar, 2000; Ellis, 2000). Cognitions contribute significantly to stress reactions, and a discussion of the role of private thoughts in stress reactions should take place with the client. As with the physiological dimension above, clients usually understand from their own experience how thinking behaviors influence their emotions.

In Lazarus's (1984) conceptualization of stress, a person's cognitive appraisal of a situation is related to a stress reaction. Clients can be instructed to monitor their thoughts surrounding stressful situations; in this way, they record their stress appraisals and become aware of irrational and distorted self-talk. A thoughts diary helps clients monitor their self-talk by recording over several days their strong emotional responses (e.g., anxiety, anger, sadness), the events that precipitated the emotions, and the thoughts that accompanied the

emotions and events. A client examines with the counselor this record of self-talk and how it may be contributing to stress reactions.

Lifestyle Awareness. Lifestyle patterns contribute to stress reactions. For example, excessive caffeine, limited physical activity, lack of proper nutrition, poor sleep habits, weak social networks, and time mismanagement may not only add to the distress of a situation, but interfere with a person's ability to cope with the situation. Clients need to learn how lifestyle behaviors contribute to stress. For example, excessive caffeine contributes to overstimulation of the nervous system; poor sleep habits and low social support interfere with healthy coping behaviors; poor nutrition increases the risk of illness. Different types of record-keeping or diaries help clients become aware of these and other lifestyle behaviors. Examples include asking clients to record all that they eat and drink over several days and keeping a time diary to monitor use of time.

The major goals of this component are to (1) teach an understanding of the relationship of physiology, thoughts, and lifestyle to stress; (2) encourage clients to increase their awareness of their reactions to stressful situations; and (3) monitor how they are presently coping with the situation. Self-awareness is important as an initial step in the change process.

Improve Coping Strategies

The second component of this framework is helping clients change, improve, or strengthen their coping strategies to better manage a stressful situation. Various interventions are available in the three domains of physiology, cognition, and lifestyle. Interventions related to these domains may overlap and are not mutually exclusive. Interventions can be utilized for remedial and preventive purposes and in individual and group applications.

Physiological Change. The flight-or-fight response disrupts physiological homeostasis during a stressful encounter. The sympathetic nervous system predominates during the response. Interventions such as relaxation training, diaphragmatic breathing, and meditation engage the parasympathetic nervous system, creating a relaxation response. These interventions give clients tools or strategies to help the body return to an increased level of homeostasis. As the parasympathetic nervous system becomes engaged, physiological changes occur; for example, heart rate is slowed, hands and fingers become warmer, and muscle tension is reduced. A major advantage of teaching clients strategies to influence their physiology is the sense of control they experience over their physiological reactions to a stressful encounter. One example is teaching clients the difference between stress-induced breathing (i.e., upper chest movement, shallow breaths) and relaxed breathing (i.e., abdomen movement, deeper breaths). One form of relaxed breathing is called diaphragmatic breathing because it utilizes the diaphragm, a muscle at the bottom of the chest cavity, to regulate the flow of oxygen into and out of the body. Diaphragmatic breathing is sometimes referred to as natural breathing because newborn infants instinctively breathe with the diaphragm. Stress reactions disrupt this natural tendency to breathe with the diaphragm. Clients can be given instruction and practice in diaphragmatic breathing and asked to utilize this strategy during stressful encounters. Diaphragmatic breathing and other forms of psychophysiological interventions have the effect of inducing emotional calmness as they engage the parasympathetic nervous system. Breathing techniques have advantages over other forms of psychophysiological interventions because they can be implemented with little or no notice from others. However, clients must remember to utilize them; I have encouraged people to make notes to themselves ("breathe with my diaphragm") in anxiety-producing situations (e.g., public speaking).

Cognitive Change. Cognitive-behavior theory (Beck & Weishaar, 2000; Ellis, 2000) has provided numerous techniques and strategies to help clients change thinking patterns that contribute to stress reactions. One type of strategy is cognitive restructuring, in which clients learn to replace irrational and distorted beliefs and thoughts with self-statements that are more rational and

realistic. Changing self-defeating and stress-producing thoughts to those that are more self-enhancing will reduce stress reactions. In terms of Lazarus's (1984) concepts of stress and coping, cognitive restructuring strategies have the potential to help clients appraise stressful situations more accurately. If a client regularly uses words such as "should," "always," "never," "everybody/nobody," and "can't," these are signs that the client's thought patterns may be self-defeating. Suggesting that clients utilize more appropriate language (e.g., "some," "most people," "I chose" rather than "I should") will reduce stress. Other cognitive strategies include thought stopping and cognitive rehearsal, which are techniques to discourage the use of self-defeating thoughts and promote self-enhancing thoughts.

One stress management intervention utilizing cognitive strategies along with other techniques is called stress inoculation training (SIT). SIT was developed by Meichenbaum and his colleagues (Meichenbaum & Jaremko, 1983) to help people prepare for stressful events. SIT inoculates people against the effects of stress situations through education, coping skills training, and application.

Lifestyle Change. Mental health professionals are well positioned to inform people about lifestyle behaviors that contribute to stress and those that may buffer the effects of stress. As behavior change experts, counselors are well qualified to initially assess problematic lifestyle behaviors and suggest possible change strategies. Psychologists and counselors may need to refer to other professionals for consultation in areas that are beyond their expertise (e.g., nutritionist, chemical dependency counselor, exercise physiologist). At times, referral to a clergy person may be necessary. Most important, however, counselors need to teach clients how lifestyles that promote well-being will help to manage stress and enhance overall health. For example, people are bombarded in the national media about the health benefits of physical exercise and diets low in sugar and saturated fats. However, clients may be less informed about the potential benefits of physical exercise as a stress management strategy (Long & Flood, 1993). They also may underestimate how misuse of time and weak social support networks may contribute to stress.

Lifestyle changes must be introduced gradually so that clients do not become discouraged and lose motivation to change. Discuss with clients changes that they are most motivated to make. Once the focus of change has been decided on, a change strategy can be developed, implemented, and regularly evaluated for effectiveness.

Strengthen Well-Being

The final component of this model teaches clients behaviors and strategies to enhance their overall well-being to buffer the effects of future stressors and life changes. In addition to physiological, cognitive, and lifestyle domains, it is recommended that clients periodically review other areas of their lives, including spiritual, family, and career. Included in these areas are themes of personal values, life meaning, hope, optimism, and life satisfaction (e.g., family, career, and interpersonal relationships).

Kobasa (1979) has studied people who are resistant to the negative health effects of stressful life events. She hypothesized that these people are characterized by a "hardy personality"; that is, they are people who exhibit a sense of personal control, are committed to their endeavors, and feel challenged by them. According to Kobasa, these characteristics serve as protective factors in stressful situations.

A holistic model of personal development, addressing several dimensions of the human condition, is highly recommended to strengthen well-being. Romano (1984) developed a holistic model of stress management in the form of a university course and reported promising results. Recently, Hoffman and Driscoll (2000) articulated a broadly conceptualized biopsychosocial model of health promotion and disease prevention to address health needs. Coping styles and stress management are important components of the model. The Wheel of Wellness is another comprehensive example of a holistic model for

health and well-being presented by Myers, Sweeney, and Witmer (2000).

Stress, coping, and well-being are important psychological constructs that have enjoyed a rich theoretical and applied history. Although much more needs to be learned about them, there is sufficient research evidence to recommend the application of these constructs for preventive and remedial applications by mental health practitioners.

References

Aldwin, C.M. (1994). *Stress, coping, and development: An integrative perspective.* New York: Guilford Press.

Beck, A.A., & Weishaar, M.E. (2000). Cognitive therapy. In R.J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (pp. 241–272). Itasca, IL: Peacock.

Benard, B. (1993, November). Fostering resiliency in kids. *Educational Leadership,* 44–48.

Cannon, E.B. (1932). *The wisdom of the body.* New York: Norton.

Coddington, R.R. (1972). The significance of life events as etiologic factors in the diseases of children: II. A study of a normal population. *Journal of Psychosomatic Research, 16,* 205–213.

Coyne, J.C., & Racioppo, M.W. (2000). Never the twain shall meet? Closing the gap between coping research and clinical intervention research. *American Psychologist, 55,* 655–664.

Dohrenwend, B.S., & Dohrenwend, B.P. (1984). Life stress and illness: Formulation of the issues. In B.S. Dohrenwend & B.P. Dohrenwend (Eds.), *Stressful life events and their contexts.* New York: Prodist.

Ellis, A. (2000). Rational emotive behavior therapy. In R.J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (pp. 168–204). Itasca, IL: Peacock.

Folkman, S., & Moskowitz Tedlie, J. (2000). Positive affect and the other side of coping. *American Psychologist, 55,* 647–654.

Garmezy, N., Masten, A.S., & Tellegen, A. (1984). The study of stress and competency in children: A building block for developmental psychopathology. *Child Development, 55,* 97–111.

Hobfoll, S.E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist, 44,* 513–524.

Hoffman, M.A., & Driscoll, J.M. (2000). Health promotion and disease prevention: A concentric biopsychosocial model of health status. In S.D. Brown & R.W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 532–567). New York: Wiley.

Holmes, T.H., & Rahe, R.H. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research, 11,* 213–218.

Kobasa, S.C. (1979). Stressful life events, personality and health: An inquiry into hardiness. *Journal of Personality and Social Psychology, 37,* 1–11.

Lazarus, R.S. (1992). Four reasons why it is difficult to demonstrate psychosocial influences on health. *Advances, the Journal of Mind-Body Health, 8,* 6–7.

Lazarus, R.S. (1993). Coping theory and research: Past, present, and future. *Psychosomatic Medicine, 15,* 234–247.

Lazarus, R.S. (2000). Toward better research on stress and coping. *American Psychologist, 55,* 665–673.

Lazarus, R.S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Lightsey, O.S. (1996). What leads to wellness? The role of psychological resources in well-being. *The Counseling Psychologist, 24,* 589–735.

Long, B.C., & Flood, K.R. (1993). Coping and work stress: Psychological benefits of exercise. *Work and Stress, 7,* 109–119.

Marx, M.B., Garrity, T.F., & Bowers, F.R. (1975). The influence of recent life experiences on the health of college freshmen. *Journal of Psychosomatic Research, 19,* 87–98.

Masten, A.S., & Coatsworth, J.D. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist, 53,* 185–204.

Masten, A.S., Neemann, J., & Andenas, S. (1994). Life events and adjustment in adolescents: The significance of event independence, desirability, and chronicity. *Journal of Research on Adolescence, 4,* 71–97.

Meichenbaum, D., & Jaremko, M.E. (1983). *Stress reduction and prevention.* New York: Plenum Press.

Myers, J.E., Sweeney, T.J., & Witmer, J.M. (2000). The Wheel of Wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling and Development, 78,* 251–266.

Rice, P.L. (1999). *Stress and health.* Pacific Grove, CA: Brooks/Cole.

Romano, J.L. (1984). Stress management and wellness: Reaching beyond the counselor's office. *Personnel and Guidance Journal, 62,* 533–536.

Romano, J.L. (1997). School personnel training for the prevention of tobacco, alcohol, and other drug use: Issues and outcomes. *Journal of Drug Education, 27,* 245–258.

Romano, J.L., & Hage, S.M. (in press). Prevention and counseling psychology: Revitalizing commitments for the 21st century. *The Counseling Psychologist.*

Sarafino, E.P. (1998). *Health psychology: Biopsychosocial interactions* (3rd ed.). New York: Wiley.

Seligman, M.E.P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55,* 5–14.

Selye, H. (1976). *The stress of life.* New York: McGraw-Hill.

Somerfield, M.R., & McCrae, R.R. (2000). Stress and coping research: Methodological challenges, theoretical advances, and clinical applications. *American Psychologist, 55,* 600–625.

8 THE FAT CLIENT

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On a daily basis, people in the United States are bombarded with images of ideal personal appearance. Mass media communications suggest that achieving the correct appearance will lead to acceptance, success, and overall happiness in life. The current standards for attractiveness include size specifications. It is not surprising, then, that some people who seek mental health care may be concerned about food and weight issues either because their actual size is different from what society deems desirable, or because they have become obsessed with maintaining a body size that already meets or exceeds societal standards. Concerns about food and weight bring anguish in many forms. The following discussion focuses specifically on providing help to those persons who are truly considered heavier than average or obese by the mental health practitioner.

The word "fat" will be used in this chapter when referring to clients. As Barron and Lear (1989) point out, the word "obese" is used in a medical context and therefore suggests that fat is a disease. "Overweight" suggests that there is really a correct weight that one is over. The word fat is used to acknowledge and honor the most accurate description of the client, in the hope that the word's derogatory connotation will fade.

If the fat person expresses concern about food and weight, the mental health practitioner needs to expand the scope of the assessment and intervention plan by considering the following:

- The influence of social/cultural beliefs and messages about size.
- Biological factors that affect size.

- Psychological ramifications of being heavier than average in a society that values thinness.

SOCIAL/CULTURAL BELIEFS AND MESSAGES ABOUT SIZE

Today in Western culture, the slender body shape is placed before the public as a standard to achieve, particularly for women. This preoccupation with thinness is a relatively recent phenomenon. Prior to the late 1800s and early 1900s, thinness was often considered unhealthy and unattractive. One factor that brought about the change in attitude was the expansion of women's roles around the turn of the century. In the late 1800s, feminist ideas emerged. Some women were attending college and many were finding jobs outside the home. At the same time, the view that women were too frail to be physically active was supplanted by the view that healthy women should be athletic. Thus, women began to enjoy more overall physical freedom. The expansion in women's roles necessitated changes in women's fashions. The cumbersome clothing styles of the past were simply no longer practical. The fashion industry responded by designing more functional clothing. The new styles were more revealing, making it more difficult for women to use clothing for body shape enhancement. Because clothing could no longer be used to cosmetically shape the body, the body became the object to be shaped (Bennett & Gurin, 1982; Seid, 1989, 1994).

By the middle of the century, the changing attitudes about appropriate weight and size were reinforced by a Metropolitan Life Insurance Company retrospective study (as cited in Bennett & Gurin, 1982) that examined the relationship between weight and mortality rates. Despite the biased samples and questionable data analyses, the findings were generalized to the entire population. The proliferation of papers generated by this insurance company's scientist was instrumental in accelerating the change in attitudes about weight and health. By the early 1950s, obesity was identified as the number one health problem in this country. Obesity became a disease to be treated by physicians; the remedy for the disease was the weight-loss diet (Bennett & Gurin, 1982; Seid 1989).

While the health care industry was busy embracing the notion that lower body weight was healthy for all, the fashion industry came along to firmly implant an association between thinness and beauty in the consciousness of the culture (Seid, 1989). In the 1960s, the appearance of the famous fashion model Twiggy (5′7″ and 98 pounds) marked the beginning of a more severe standard for thinness, which continues to be idealized today (Seid, 1994).

In the decades after the 1960s, the models for female beauty became increasingly thinner and less likely to resemble what the average American woman could realistically achieve. For example, Garner, Garfinkel, Schwartz, and Thompson (1980) found that the Miss America contestants during the period from 1959 to 1978 showed a trend toward decreasing weights at the same time that American women were increasing in weight. In an update of this research, Wiseman, Gray, Mosimann, and Ahrens (1992) found that the Miss America contestants' body weights continued to decrease between 1979 and 1988. During this period, the reported Miss America body weights were 13% to 19% below the weights that would be expected for women of their ages. These authors point out that maintaining a weight of 15% below the expected weight is one criterion for the diagnosis of anorexia nervosa.

Today, the pursuit of thinness remains quite popular. For instance, results of a recent survey of U.S. college students (Centers for Disease Control and Prevention, 1997) indicated that 41.6% of students considered themselves to be overweight, even though only 20.5% were classified as overweight. Female students were more likely to consider themselves overweight than male students. The report states that 46.4% of the college student respondents were attempting to lose weight. Overall, one-third of college students have used dieting as a means to control weight and about one-half have used exercise.

Media messages continue to promote the concept that weight loss is a goal that the acceptable person will achieve. The messages mainly affect females. Levine and Smolak (1996) found that weight loss is glorified in magazines and through televised messages that adolescent girls and young women are likely to see. Wertheim, Paxton, Schutz, and Muir (1997) found that girls responded to the thin ideal pictured in the media by feeling pressured to be thin. Pinhas, Toner, Ale, Garfinkel, and Stuckless (1999) report that the women in their study felt angrier and had an increase in depressed mood after looking at pictures of the thin models from common fashion magazines. While conducting a content analysis of popular magazines, Malkin, Wornian, and Chrisler (1999) discovered that 94% of women's magazines showed thin females on the cover. They also found that the magazine covers displayed messages about weight that were positioned next to other messages with the implication that weight loss will lead to an improved life.

When reviewing the literature on weight loss issues, several themes emerge (Kilbourne, 1994; Nichter & Nichter, 1991; Seid, 1989):

- Advertisers have an interest in keeping consumers dissatisfied with themselves because profit depends on selling something that the consumer lacks. There is no incentive to tell consumers, especially women, that they are perfectly acceptable just as they are.
- To ward off uncomfortable reminders that life is full of uncertainties, great value is placed on "being in control" in our culture. Weight has become symbolically linked to control. Those considered fat are viewed as violators of the mandate for control and are consequently judged as lacking in virtue.
- Satisfying versus suppressing the appetite for food has become a moral issue for persons of all sizes, especially for fat people.

Naturally, the impact of living in this social context may be quite significant for the fat person. As early as 1962 researchers found that there was a correlation between obesity and socioeconomic status, with the highest percentage of obese women falling into the lowest socioeconomic status group. Men showed a similar trend to a lesser degree (Moore, Stunkard, & Srole, 1962). More recently, a seven-year follow-up of subjects who were overweight during adolescence and early adulthood found that the women had completed fewer years of school, were not as likely to be married, and were more likely to live in poverty than women who had not been overweight. These researchers believe that their findings support the position that socioeconomic status is a consequence of being overweight, and they question the assumption that being overweight is due to socioeconomic status (Gortmaker, Must, Perrin, Sobol, & Dietz, 1993).

Rothblum and associates (1990) found that the very obese participants in their research reported experiencing various types of employment discrimination. Both obese and very obese people also reported school victimization, including being called negative weight-related names, being excluded from sports or social activities, and being victims of discrimination by teachers.

Access to appropriate medical care is a concern for obese people. Some have been denied health insurance because of their weight (Rothblum, Brand, Miller, & Oetjen, 1990). Some may not have adequate health care simply because they are poor and cannot afford health insurance and preventive care (Rothblum, 1994). Some are reluctant to seek medical care because they anticipate receiving abuse and admonitions about weight from their physicians, regardless of the symptom for which treatment is sought (Burgard & Lyons, 1994).

Finally, Seid (1989) notes that the cruelest and most damaging thing the fashion industry did in the 1960s was to convey the idea that anyone could become thin. The health care industry supported this notion as well. The assumption that thinness is attainable by everyone persists. This view is particularly distressing given the evidence that biological

realities are in conflict with the cultural mandate to be thin.

BIOLOGICAL FACTORS THAT AFFECT SIZE

The set point theory holds that the body has a built-in system that determines how much fat is needed (Nisbett, 1972). When a person tries to reduce the fat stores through a weight-loss diet, biological changes occur. These changes are actually designed to help the body survive through times of famine. Metabolic rates decrease and calories are burned more slowly to defend the fat stores. The dieter may notice that weight loss slows or stops altogether. Soon, the dieter will experience intense hunger and may feel compelled to eat. When eating occurs, weight is gained more easily because the metabolic rate is lowered (Bennett & Gurin, 1982; Leibel, Rosenbaum, & Hirsch, 1995). Most dieters will regain the weight lost within two to five years and many will weigh more than they did before the diet (Garner & Wooley, 1991).

When working with the fat client, the mental health practitioner should keep the following in mind:

- Fat people do not eat more than lean people. A fat person may need to eat considerably less than the lean person to maintain an average body size (Garner & Wooley, 1991).
- Different people can eat the same amount of food and have very different body sizes (Bouchard et al., 1990).
- Genes appear to influence body fatness, and the childhood environment has little or no effect (Stunkard et al., 1986).
- A body mass index (BMI) in the 26 to 28 range is considered over the ideal weight. BMI is weight in kilograms divided by the square of height in meters (kg/m^2). Longitudinal studies show that BMIs in this range do not necessarily result in increased mortality rates (Ernsberger & Haskew, 1987; Troiano, Frongillo, Sobal, & Levitsky, 1996).
- Weight loss can reduce cholesterol and blood pressure and improve glucose tolerance, but these health benefits disappear with the regaining of weight and often are more problematic than prior to the weight loss (Garner & Wooley, 1991).
- Weight cycling (repeatedly losing and regaining weight) is associated with higher rates of death from coronary heart disease and death from all causes (Brownell & Rodin, 1994; Lissner et al., 1991).
- Persons who gain a modest amount of weight during adulthood have the lowest mortality rates, and weight loss is associated with higher mortality rates (Andres, Muller, & Sorkin, 1993; Pamuk et al., 1992).
- Normal daily calorie intake for adults may range from 2,400 to 3,000 calories per day. Most weight-loss diets prescribe 945 to 1,200 calories per day. The World Health Organization states that 900 or fewer calories qualifies as starvation (*www.naafa.org*).
- Hunger is managed best through eating at regular, predictable intervals (Wooley, Wooley, & Dyrenforth, 1979).

Because there are hazards associated with weight loss, experts recommend lifestyle changes that promote health for persons of any size (I. Kedd, 2000). This involves incremental, moderate changes in eating and exercise habits that can be realistically sustained over time. The health benefits are immediate. For example, a study comparing fitness levels in overweight and normal-weight men found a lower risk of mortality in the physically fit regardless of size (Barlow, Kohl, Gibbons, & Blair, 1995). Although there is much conflicting information about healthy eating, authorities seem to agree that eating a varied diet that incorporates favorite foods, fruits, vegetables, and whole grains is most beneficial; they also recommend limiting portions of foods high in fat (Berg, 1993; Burgard & Lyons, 1994). Research indicates that blood pressure can be reduced by diet content (Appel et al., 1997). Also, risk factors for coronary artery disease can be reduced by using a combination of dietary content and exercise even for people who remain fat (Barnard, Ugianskis, Martin, & Inkeles, 1992).

PSYCHOLOGICAL RAMIFICATIONS OF BEING FAT IN A SOCIETY THAT VALUES THINNESS

In both the general and professional literature, there has been a tendency to view a person's weight-loss failures as the result of a psychological defect. Of course, fat people have the same range of difficulties and disturbances as people of any size, but studies have found that the rate of psychopathology in the obese population is similar to the rate in the nonobese population. So the idea that people are fat because they have psychological disturbance has been refuted (Stunkard & Wadden, 1992). However, some psychological symptoms that fat people present to mental health professionals are actually the offshoots of being fat in a society that values thinness. Symptoms that are really the psychological ramifications of being fat include distorted relationships with food, problematic emotions associated with food deprivation, and self-deprecating responses to the prejudices about size.

Many fat people have tried weight-loss diets. Often, they want very much to comply with societal expectations. For some, the repeated efforts to lose weight have resulted in distorted relationships with food, which may become manifest in the following ways:

- Binge eating and some overeating can be a consequence of the body's push to restore fat after restrictions in food intake. This particular eating compulsion is a biological survival mechanism and is not necessarily indicative of psychological pathology (Polivy, 1996; Telch & Agras, 1993).
- The fat person has been trained and encouraged to limit food intake, so that normal eating (eating in response to internal hunger signals) seems forbidden (Polivy, 1996).
- Even when not overeating, the fat person may be apologetic about the amount of food consumed and may even feel the need to hide when eating (Polivy, 1996).

Unfortunately, the amount of food required to stabilize eating patterns and improve emotions will often lead to fears of weight gain. Weight gain is perceived as failure. For the perennial dieter, the decision to stop dieting is a significant psychological step that means parting with the dream of being thin. The fat client may need time to accept the fact that permanent size reduction is an unattainable goal and to develop a new way of thinking about self and food.

For some people, even with adequate food intake over time, significant overeating or binge eating may continue. When the person has experienced food deprivation, even if intermittently, food can take on exaggerated importance. The good feeling one gets by satisfying hunger seems to get confused with soothing emotional pain. Overeating consistently used to ease emotional pain does not occur in all cases, as the popular media suggests. When overeating does occur in this manner, however, it can be quite alarming for the individual.

Many unpleasant emotional reactions are associated with food deprivation. These include irritability, anxiety, mood swings, and depressive symptoms (Garner & Wooley, 1991; Polivy, 1996). Adequate nourishment is needed for optimal psychological functioning. When eating returns to normal, these emotional changes may subside.

Finally, fat people have different psychological reactions to societal prejudice and discrimination. Those who subscribe to the view that weight is under their control accept society's condemnation of their size and consider themselves at fault for their own condition. In contrast, some fat people recognize the distortions in the media and in the public's thinking about weight and do not accept the view that they are defective or deficient (Crocker, Crornwell, & Major, 1993). Responses to this hostile environment range from total self-deprecation to fat activism.

ASSESSMENT

For clients of any size, especially females, food and weight issues may be a concern. The fat client may or may not express concern about these issues. As part of the usual assessment process, the mental health practitioner may

mention that food and weight issues are of great concern to many people living in this culture and then may ask if these issues are a concern for the client. If the client indicates that there are no concerns in this area, the exploration is ended. The mention of the subject gives the client permission to revisit the topic at a later time. If the client expresses concern about food and weight issues, the assessment should be expanded to include a discussion of dieting history, current eating patterns, level of physical activity, and expectations about any problems that will be solved as a result of resolving food and weight issues.

Dieting History

The dieting history provides some indication of clients' long-term relationship with food as well as their understanding of why past attempts at resolving food and weight issues have not been successful. The following questions can be used to explore the dieting history:

- How many diets have been tried?
- What types of diets were tried?
- Approximately when did the dieting take place?
- How much weight was regained after each diet?
- Were there any emotional changes when dieting?
- What is your understanding of the reason for lack of success with weight loss?

Current Eating Patterns

Clients' eating patterns may range from normal to somewhat problematic to so troubled that a formal eating disorder diagnosis is warranted. The practitioner may discover that a client's eating falls within a normal pattern even when the client defines the eating as problematic: The client believes that something must be wrong with the eating pattern because a heavy weight is maintained. Clients may express some conflicts about food because eating has been discouraged. Some clients may be engaging in binge-purge behaviors that would put the eating pattern in the bulimic category.

For many practitioners and clients as well, there can be a great temptation to focus on how much food the client is eating with little attention to the overall pattern of eating. If the person is truly binge eating or consistently overeating, the usual pattern includes some period of deprivation that precedes the overeating. The client could be experiencing a rebound from a recent weight-loss diet or perhaps the client does not eat all day and then eats continuously at night. The deprivation must be understood and addressed to help the client become free of food obsessions. To obtain the pertinent information about eating patterns, the following questions may be asked:

- It is helpful to know the details about the most recent diet. What type of diet did you try and when did it occur? What have you noticed about eating patterns since the diet?
- Describe the way you eat on a typical day. What do you consider to be a good eating day? What is a bad day? Do you have foods that you consider good or bad? If so, please explain.
- Do you see a connection between your emotions and your eating pattern?
- Most people overeat at times. Some people feel that they overeat constantly. How would you describe your overeating?
- Do you ever binge eat? If so, how often, when does the binge occur, and what is consumed?
- Sometimes, people try to maintain a lower weight by trying not to eat, by vomiting after eating, by using laxatives, or by exercising extensively. Have you used any of these methods to control weight?

Exercise

A review of the exercise history and current activity level is important for several reasons. Some clients may be supporting their own health currently by engaging in regular physical activity, but they may be discouraged

because significant weight loss has not occurred. Some may have gained weight after an injury or illness resulted in a need to limit activity, so accommodations may be needed for the person to remain active. Some may be reluctant to exercise because they fear being ridiculed if exposed to the public eye. The questions related to exercise include:

- Do you exercise or engage in any type of physical activity?
- Do you have any physical problems that require you to limit your physical activity?
- If you are not currently engaged in any kind of regular physical activity, do you have any concerns that prevent you from being active (e.g., don't want to put on a leotard and go to the aerobics class with all the thin women)?

Goals Accomplished by Losing Weight

People of all sizes focus energy on losing weight in part because being thinner may be the means by which another goal is attained. Perhaps the weight loss is intended to bring greater social acceptance or improved health. Questions should be designed to help clients reveal the goal(s) that are ultimately to be accomplished by losing weight. Responses to the following questions will help the practitioner to further clarify the clients' goals:

- What was happening in your life that made you decide to try to lose weight?
- How would your life be better if you lost weight?

When the information about dieting, eating patterns, exercise, and goals to be accomplished by weight loss is added to the information gathered in the usual assessment process, the client's issues usually fall into one of five categories. As we delineated in an earlier article (Melcher & Bostwick, 1998) the categories are:

- *Normal but Doesn't Know It*—she functions well in all or most areas of her life and eating is actually normal. She believes that she must be doing something wrong because she is heavier than average. She may be asking for help at this moment in her life because of some normal developmental shift, which causes her to reflect upon where she is in life. For example, she may turn 30 and become more concerned about the fact that she's not married. She believes that weight loss is required in order to meet this and other life goals;
- *Well-Adjusted Overeater*—this person functions well. However, she may be overeating or perhaps binge eating because she has been dieting and/or excessively exercising;
- *Emotionally Troubled Normal Eater*—this person is not overeating, but believes that an eating problem exists because she is heavier than average. She has emotional issues that cause problems in functioning but these are not necessarily related to her weight;
- *Emotionally Troubled Overeater*—this person is involved in overeating or problematic eating and has co-existing emotional problems. In this case, the social worker still needs to know whether there has been recent food deprivation because, as in the other cases, the effort to diet is contributing to the eating problem. For this individual, when food deprivation no longer exists there may be continued use of food to help with managing a variety of emotions (e.g., anxiety, depression); and,
- *Normal and Knows It*—this person is heavier than average, has accepted her size, functions well, and does not overeat. However, she may feel lonely because few people understand her situation and she may feel exhausted by societal discrimination. (p. 200)

INTERVENTION

With the possible exception of the "normal and knows it" client, all of the clients in the four remaining categories need information about the arbitrary nature of size stipulations in Western culture, about the pitfalls of weight-loss dieting, and about the option of

living in a manner that promotes health regardless of size. An ideal way to transmit such information is through a psychoeducational group. In a psychoeducational group, clients receive information, have the opportunity to discuss how the information applies to their own situation, and receive group support (Ciliska, 1998).

If no group is available, the mental health practitioner may certainly share this information with individual clients. When working with an individual, the delivery of the information is paced to address the specific concerns of that client. Time is allowed for discussion of the client's reactions to the information and for therapeutic input from the practitioner.

If the client's eating pattern is in the normal range, this assessment should be shared with the client. Clients may respond to this news with mixed feelings of relief for not being at fault for their size, and sadness because thinness has eluded them.

If the client's eating pattern is problematic, intervention calls for some discussion of how this individual might plan to schedule meals at regular intervals. The client needs to work toward knowing that food will be available at regular intervals (e.g., breakfast, lunch, and dinner, or lunch, dinner, and evening snack) to stop overeating. Some of the overeating may be an attempt to hoard food before the next famine. Techniques such as sitting comfortably at a place designated only for eating and avoiding other activities, such as watching TV or reading while eating, can help the person focus on eating in response to internal signals. Some clients may want to give up the effort to improve eating patterns if episodes of overeating occur, so they need reassurance that returning to their old, familiar eating pattern is expected. Following the plan perfectly may be essential for losing weight, but it is not required for developing a more satisfying relationship with food (Roth, 1984).

Assessment of emotional difficulties is an ongoing process if the eating is restricted. Some dysphoria may be the result of inadequate nourishment. When there are diagnosable emotional problems, proceed with treatment as usual. If one mental health practitioner is working with the food and weight issues as well as the more general mental health concerns, discussion of the two areas can be blended. If overeating is truly used to cope with emotional upsets, then the connection between each precipitating event and eating must be explored to help the client find a more productive way of responding.

Finally, a few other things to consider:

- A referral can be made to a dietitian who agrees with a size acceptance philosophy for help with the problem eating.
- A consultation with a physical therapist or exercise physiologist might be useful to the person who has physical problems that interfere with becoming physically active.
- Sometimes, meetings that include the client and family members or significant others may be useful for educating all involved and for helping clients communicate their needs about food and weight issues to those who are closest to them.
- Contact with a support group or with a size acceptance organization can help clients maintain self-acceptance and feel less isolated. One helpful resource is the National Association to Advance Fat Acceptance (NAAFA—www.naafa.org).

References

Andres, R., Muller, D.C., & Sorkin, J.D. (1993). Long-term effects of change in body weight on all-cause mortality. *Annals of Internal Medicine, 119*(7, Pt. 2), 737–743.

Appel, L.J., Moore, T.J., Obarzanek, E., Vollmer, W.M., Svetkey, L.P., Sacks, F.M., Bray, G.A., Vogt, T.M., Cutler, J.A., Windhauser, M.M., Lin, P., Karanja, N. (1997). A clinical trial of the effects of dietary patterns on blood pressure. *New England Journal of Medicine, 336*(16), 1117–1124.

Barlow, C.E., Kohl, H.W., III, Gibbons, L.W., & Blair, S.N. (1995). Physical fitness, mortality and obesity. *International Journal of Obesity, 19*(Suppl. 4), 41–44.

Barnard, R.J., Ugianskis, E.J., Martin, D.A., & Inkeles, S.B. (1992). Role of diet and exercise in the management of hyperinsulinemia and associated

atherosclerotic risk factors. *American Journal of Cardiology, 69,* 440–444.

Barron, N., & Lear, B.H. (1989). Ample opportunity for fat women. In L. Brown & E. Rothblum (Eds.), *Fat oppression and psychotherapy: A feminist perspective.* Binghamton, NY: Haworth Press.

Bennett, W., & Gurin, J. (1982). *The dieter's dilemma.* New York: Basic Books.

Berg, F.M. (1993). *The health risks of weight loss.* Hettinger, ND: Obesity and Health.

Bouchard, C., Tremblay, A., Després, J., Nadeau, A., Lupien, P., Thériault, G., Dussault, J., Moorjani, S., Pinault, S., & Fournier, G. (1990). The response to long-term overfeeding in identical twins. *New England Journal of Medicine, 322*(21), 1477–1482.

Brownell, K.D., & Rodin, J. (1994). Medical, metabolic, and psychological effects of weight cycling. *Archives of Internal Medicine, 154,* 1325–1330.

Burgard, D., & Lyons, P. (1994). Alternatives in obesity treatment: Focusing on health for fat women. In P. Fallon, M.A. Katzman, & S.C. Wooley (Eds.), *Feminist perspectives on eating disorders.* New York: Guilford Press.

Centers for Disease Control and Prevention. (1997). *Youth risk behavior surveillance: National college health risk behavior survey—United States, 1995,* 46(ss-6), 1–54. Retrieved May 10, 2000. Available: www.cdc.gov/nccdphp/dash/MMWRFiles/ss4606.html.

Ciliska, D. (1998). Evaluation of two nondieting interventions for obese women. *Western Journal of Nursing Research, 20*(1), 119–135.

Crocker, J., Cornwell, B., & Major, B. (1993). The stigma of overweight: Affective consequences of attributional ambiguity. *Journal of Personality and Social Psychology, 64*(1), 60–70.

Ernsberger, P., & Haskew, P. (1987). *Rethinking obesity: An alternative view of its health implications.* New York: Human Sciences Press.

Garner, D.M., Garfinkel, P.E., Schwartz, D., & Thompson, M. (1980). Cultural expectations of thinness in women. *Psychological Reports, 47,* 483–491.

Garner, D.M., & Wooley, S.C. (1991). Confronting the failure of behavioral and dietary treatments for obesity. *Clinical Psychology Review, 11,* 729–780.

Gortmaker, S.L., Must, A., Perrin, J.M., Sobol, A.M., & Dietz, W.H. (1993). Social and economic consequences of overweight in adolescence and young adulthood. *New England Journal of Medicine, 329*(14), 1008–1012.

Ikedd, J.P. (2000, January/February). Health promotion: A size acceptance approach. *Healthy Weight Journal, 14,* 12–14.

Kilbourne, J. (1994). Still killing us softly: Advertising and the obsession with thinness. In P. Fallon, M.A. Katzman, & S.C. Wooley (Eds.), *Feminist perspectives on eating disorders.* New York: Guilford Press.

Leibel, R.L., Rosenbaum, M., & Hirsch, J. (1995). Changes in energy expenditure resulting from altered body weight. *New England Journal of Medicine, 332*(10), 621–628.

Levine, M.P., & Smolak, L. (1996). Media as a context for the development of disordered eating. In L. Smolak, M.P. Levine, & R. Striegel-Moore (Eds.), *The developmental psychopathology of eating disorders: Implications for research, prevention, and treatment.* Mahwah, NJ: Erlbaum.

Lissner, L., Odell, P.M., D'Agostino, R.B., Stokes, J., III, Kreger, B.E., Belanger, A.J., & Brownell, K.D. (1991). Variability of body weight and health outcomes in the Framingham population. *New England Journal of Medicine, 324*(26), 1839–1844.

Malkin, A.R., Wornian, K., & Chrisler, J.C. (1999). Women and weight: Gendered messages on magazine covers. *Sex Roles, 40*(7/8), 647–655.

Melcher, J., & Bostwick, G.J., Jr. (1998). The obese client: Myths, facts, assessment, and intervention. *Health and Social Work, 23*(3), 195–202.

Moore, M., Stunkard, A., & Srole, L. (1962). Obesity, social class, and mental illness. *Journal of the American Medical Association, 181*(11), 962–966.

National Association to Advance Fat Acceptance. *Weight loss: Fact and fiction.* Sacramento, CA: Author. Retrieved June 20, 2000. Available: www.naafa.org

Nichter, M., & Nichter, M. (1991). Hype and weight. *Medical Anthropology, 13,* 249–284.

Nisbett, R.E. (1972). Hunger, obesity, and the ventromedial hypothalamus. *Psychological Review, 79*(6), 433–453.

Pamuk, E.R., Williamson, D.F., Madans, J., Serdula, M.K., Kleinman, J.C., & Byers, T. (1992). Weight loss and mortality in a national cohort of adults, 1971–1987. *American Journal of Epidemiology, 136*(6), 686–697.

Pinhas, L., Toner, B.B., Ali, A., Garfinkel, P.E., & Stuckless, N. (1999). The effects of the ideal of female beauty on mood and body satisfaction. *International Journal of Eating Disorders 25*(2), 223–226.

Polivy, J. (1996). Psychological consequences of food restriction. *Journal of the American Dietetic Association, 96*(6), 589–592.

Roth, G. (1984). *Breaking free from compulsive eating.* New York: Signet Book.

Rothblum, E.D. (1994). "I'll die for the revolution but don't ask me not to diet": Feminism and the continued stigmatization of obesity. In P. Fallon, M.A. Katzman, & S.C. Wooley (Eds.), *Feminist perspectives on eating disorders.* New York: Guilford Press.

Rothblum, E.D., Brand, P.A., Miller, C.P., & Oetjen, H.A. (1990). The relationship between obesity, employment discrimination, and employment related victimization. *Journal of Vocational Behavior, 37,* 251–266.

Seid, R.P. (1989). *Never too thin: Why women are at war with their bodies.* New York: Prentice Hall Press.

Seid, R.P. (1994). Too "close to the bone": The historical context for women's obsession with slenderness. In P. Fallon, M.A. Katzman, & S.C. Wooley (Eds.), *Feminist perspectives on eating disorders.* New York: Guilford Press.

Stunkard, A.J., Sorensen, T.I.A., Hanis, C., Teasdale, T.W., Chakraborty, R., Schull, W.J., & Schulsinger, F. (1986). An adoption study of human obesity. *New England Journal of Medicine, 314*(4), 193–198.

Stunkard, A.J., & Wadden, T.A. (1992). Psychological aspects of severe obesity. *American Journal of Clinical Nutrition, 55*(Suppl.), 524–532.

Telch, C.F., & Agras, W.S. (1993). The effects of a very low calorie diet on binge eating. *Behavior Therapy, 24,* 177–193.

Troiano, R.P., Frongillo, E.A., Jr., Sobal, J., & Levitsky, D.A. (1996). The relationship between body weight and mortality: A quantitative analysis of combined information from existing studies. *International Journal of Obesity, 20,* 63–75.

Wertheim, E.H., Paxton, S.J., Schutz, H.K., & Muir, S.L. (1997). Why do adolescent girls watch their weight? An interview study examining sociocultural pressures to be thin. *Journal of Psychosomatic Research, 42*(4), 345–355.

Wiseman, C.V., Gray, J.J., Mosimann, J.E., & Ahrens, A.H. (1992). Cultural expectations of thinness in women: An update. *International Journal of Eating Disorders, 11*(1), 85–89.

Wooley, S.C., Wooley, O.W., & Dyrenforth, S.R. (1979). Theoretical, practical, and social issues in behavioral treatments of obesity. *Journal of Applied Behavior Analysis, 12*(1), 3–25.

9 GUIDELINES FOR COUNSELING CLIENTS WITH HIV SPECTRUM DISORDERS

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Over 800,000 AIDS cases have been reported in the United States, and the numbers of persons infected with HIV continue to rise (Centers for Disease Control and Prevention [CDC], 1999). Counselors are needed to treat clients and their family and friends who are impacted by this disease, including those who are newly diagnosed, those who are challenged with multiple opportunistic infections, and those facing end-of-life issues. It

thus becomes increasingly important for counselors to be aware of the unique issues involved with persons living with HIV/AIDS and to possess some conceptualizations and tools with which they can effectively interface with their clients.

DEFINITIONS AND KEY CONCEPTS

HIV (Human Immunodeficiency Virus) is the retrovirus that causes AIDS. Infection with HIV leads to changes in the immune system that can result in a cluster of symptoms recognized as *AIDS (Acquired Immunodeficiency Syndrome),* a viral disease that impairs the body's ability to fight other diseases. Persons who test positive for HIV have the virus in their system; however, they may or may not be symptomatic. As the disease progresses and the immune system becomes further compromised, the *HIV-positive* person becomes more susceptible to certain unique opportunistic infections. To be *diagnosed with AIDS,* a person must have a T-helper lymphocyte blood count of less than 200 and have had one or more opportunistic infections. The infections often can be treated, but there is no current cure for the underlying immune deficiency caused by HIV. The course of the illness can be unpredictable; some persons progress from being HIV positive and asymptomatic to developing full-blown AIDS very quickly; others remain asymptomatic indefinitely.

Early intervention, referring to the identification of people with HIV and procurement of corresponding medical and psychological treatment, is encouraged. This has become especially salient since the newer class of drugs, protease inhibitors, used in combination with other drugs (e.g., AZT), has been found to slow the progression of the disease significantly. However, the new drug treatment, often referred to as a drug cocktail, has its own set of complex issues (Britton, 2000). HIV-positive people may be required to take many drugs on a rigid schedule and experience debilitating side effects. Moreover, unless prescriptions are adhered to strictly, the virus develops a resistance to the drugs very quickly. These resistant forms of the virus may then be transmitted to others who will not respond to the drug treatments.

In an infected person, the virus can be found in body fluids, including blood, semen, vaginal and cervical secretions, and breast milk. It is most often transmitted by direct exposure to blood by certain acts of sexual intercourse and by needle sharing. Although it is possible for a woman to infect her fetus during gestation, birth, or nursing, the numbers of infection in this manner have decreased due to preventive treatments during pregnancy and birth.

MULTICULTURAL ISSUES

There is a disproportionate percentage of AIDS cases among people belonging to minority cultures, including drug use cultures, racial and ethnic minorities (particularly African Americans and Latinos), women (especially women of color), youth (the highest rate of transmission is among adolescents), gay and bisexual men, and people who are homeless or mentally disabled. Of new cases of persons with diagnosed HIV (not AIDS) reported to the CDC in 1999, 32% were women, and 77% of these women were African Americans or Latinas. Among men, African Americans and Latinos accounted for 59% of the new cases (CDC, 1999).

Counselors need to be informed about different cultures and maintain a perspective that honors and respects diversity. Winiarski (1997) has recommended that counselors working with persons with HIV disease expand their skills and knowledge regarding different cultures, paying special attention to:

Issues around stigmatization: People from oppressed groups frequently have difficulty trusting outsiders and institutions. Thus, it is important not to interpret problems with self-disclosure as resistance or avoidance.

Nontraditional healing methods: It is important to consider how the culture conceptualizes illness, death, and dying.

Views on counseling: Some cultures view counseling as supportive, but others may be very uncomfortable discussing personal information with someone outside the family or church.

UNIQUE ISSUES RELATED TO HIV/AIDS

Although many of the issues that clients impacted by HIV/AIDS deal with are similar to those of people with other chronic illnesses, there are some unique variables that set HIV/AIDS apart from other diseases:

1. *Stigma.* As HIV/AIDS has disproportionately impacted socially stigmatized populations and its transmission involves stigmatized activities (sexual activity and drug use), people with HIV disease are often perceived negatively.
2. *Unpredictability.* With most other diseases, there is a somewhat predictable course of the disease, and people are given information as to what to expect at certain stages. However, with AIDS, people have little guidance as to what to expect, often vacillating from wellness to illness. Subsequently, they can make decisions such as leaving their job, selling their home, and preparing for death, only to find themselves feeling healthy again. This unpredictability has been compared to a roller-coaster ride, with emotions fluctuating from despair to hope and back again to despair. As a result, clients report chronic apprehension and a feeling of being out of control.
3. *Isolation.* Due to the nature of transmission, HIV can be an isolating disease. People frequently struggle with maintaining healthy sexual and intimate relationships and as a result may end up feeling intensely alone.
4. *Age and Stage Differences.* HIV/AIDS tends to infect younger people who are being asked to deal with developmental concerns that most often do not impact people until they are in their later stages of life. It is common for a 75-year-old person to be dealing with end-of-life planning; however, most 25-year-olds are not prepared to deal with these issues but instead are facing career and life-planning issues.

COUNSELING AND HIV TESTING

Testing for HIV has become a complicated issue. Although there has been a push for early identification of people with HIV based on medical advances, there are psychosocial complexities around testing. There is real potential for discrimination in finding out one's HIV status, such as denial of insurance, housing, and employment.

Things to Know about HIV Antibody Testing

The HIV antibody tests are very accurate. They determine whether antibodies are present in the bloodstream; however, they do not make a diagnosis of AIDS. The two most common tests are the preliminary screening test, ELISA (enzyme linked immunosorbent assay), and the confirmatory test, Western Blot.

Home testing kits are now available; however, they are more accurately described as at-home collection kits. They have made testing more accessible to people in rural communities, but raise concern regarding the adequacy of posttest counseling. Rapid tests, available at some labs, allow for results in 5 to 30 minutes; however, a major drawback of this type of testing is the higher rate of false positives until confirmatory tests are administered.

Testing can be *confidential* or *anonymous.* Confidential testing is similar to other medical tests and accessible within certain limitations. Anonymous testing is done without use of names or identifiable information and is inaccessible to anyone but the recipient. Many who get tested do not return for results. In most settings, pre- and postcounseling accompany testing.

Counseling Issues Associated with Testing

Counselors can play a very salient role around testing issues. Common counseling themes include:

Dealing with feelings about being tested (e.g., ambivalence, fear).

Supporting clients while they wait for results.

Education about HIV/AIDS.

Dealing with results of test and acute distress that may result.

DEVELOPMENTAL MODEL OF TREATMENT

This model is based on several development models, including readiness models (e.g., Prochaska, DiClemente, & Norcross, 1992) and crisis models (e.g., Nichols, 1985). The model's central idea is that AIDS is a disease of adjustment and change. Thus, certain counseling interventions may be more effective than others during different phases of adjustment. (The model serves only as a guide; the unique needs of each client will interface with the efficacy of any intervention.)

Stage 1: Crisis

When first discovering their HIV status, most infected people will experience acute distress; however, their reaction to the crisis is a unique process. Many report depression, anxiety, and preoccupation with illness, including intense fatalism or the belief that they will die soon. Denial is another common initial reaction characterized by a description of feeling "nothing" or "numb." Many present with symptoms of an adjustment disorder; however, people can have other reactions that are within the range of "normal."

At this stage, the counselor's task is to provide crisis intervention and supportive counseling to facilitate coping. It is helpful to normalize clients' responses and assist them in managing their emotional reactions. This may include assessing support networks and making referrals, such as pastoral counseling, Alcoholics Anonymous, legal guidance, medical/dental health care, testing sites, gay community resources, and methadone clinics.

This is not the time to delve into emotional responses, nor is it the best time for education, as a person in crisis usually cannot clearly process new information. However, it may be one of the few times a person with HIV disease has access to counseling (e.g., posttest counseling), so it can be helpful to provide persons with information that they can refer to later (such as written material or pamphlets). It is also not the best time for a psychological assessment. The client's acute reaction may not reflect premorbid diagnosis but a natural reaction to crisis. Instead, a counselor should provide support, resources, and a calming presence.

Stage 2: Adjustment

Although acute distress is almost universal at beginning stages of HIV/AIDS, it usually decreases after a few weeks. The next phase involves digesting the information about oneself and finding ways to handle it. The tasks involve making some decisions about work and living arrangements as well as personal relationships.

As in phase 1, this process is unique for each individual. Some people do not experience any emotional problems during the asympotmatic phases of HIV disease. Others remain in denial, which can be a necessary and beneficial means of coping. However, denial that persists for extended periods of time can delay the onset of medical treatment and may have deleterious health effects.

Stage 2 is often characterized by a decrease in denial. Instead, people may be faced with a vacillation of denial with acute symptoms. It is also a time of high risk for substance abuse and suicide.

Disclosure Issues. A common theme during this stage involves issues around who and how to tell about one's HIV status. Counselors need to be cognizant of and sensitive to the dilemmas around disclosure, including potential for prejudice, challenges to sexual and intimate relationships, being labeled an unfit parent, vulnerability to violence, loss of job and insurance, and disclosure of sexual orientation or past drug behavior. The counseling relationship is a helpful place for clients to explore disclosure issues and subsequently be more planful and prepared.

Issues around Medical Treatment. As people more deeply acknowledge their HIV status or when confronted with their first HIV symptoms, they are often faced with difficult medical decisions. Many are encouraged to take medications early, often prior to any symptoms. The strategy is a challenge because of the potential for side effects. Issues of compliance and adherence are critical. Counseling can assist clients in processing and making decisions around their medical care, including helping people:

- Take responsibility for their own health.
- Observe and report symptoms to physician.
- Develop partnerships with physicians.
- Comply with treatment.
- Understand and keep track of medications.
- Prepare for and utilize medical appointments.
- Become good consumers of treatment.
- Assert rights.

Suicide. People with HIV infection have higher levels of suicidal ideation and more frequent attempts when compared with their non-HIV-infected counterparts. Risk of suicide appears higher in people relatively early on in the HIV disease (Marzuk et al., 1997). Unique correlations to suicidal ideation in persons with HIV disease include: onset of symptoms, number of close friends diagnosed with HIV, knowing someone who died from AIDS, and perceived risk of developing AIDS.

Counseling Interventions. A counselor's role during this stage is to provide ongoing and unconditional support. Counselors should continue to accept the affective experiences of clients, normalizing their range of feelings, such as fear, anxiety, depression, and pleasure. This is a good time to refer clients for group work, as groups can provide identification and expression of feelings, social involvement, security in the continuity and structure of a group, safety, modeling of adaptation to disease, opportunity for touch, new perspectives, and education (e.g., medical information, derailing myths).

Stage 3: Acceptance

During this phase, people begin to form a new sense of equilibrium: the formation of a new, more stable identity. Clients begin to accept their limitations but still manage their lives. They may talk about living with AIDS versus dying from AIDS.

Interpersonal and insight therapy is appropriate at this stage and may involve a multitude of themes, including:

- Family of origin work.
- Establishing emotional, physical, and sexual contact with others.
- Boundary development and setting healthy limits.
- Coming-out issues.
- Self-awareness and attending to one's own experiences.
- Exploration of meanings and purpose.
- Communication work.
- Spiritual exploration (e.g., finding appreciation for small pleasures, a capacity to live life in the present and to its fullest, focusing on quality versus quantity of life).

Diagnosing Depression and Anxiety. During this phase, psychological assessments are indicated. However, assessment is complicated because of the overlapping symptoms of HIV disease with depression/anxiety. Thus, characteristics of HIV disease should be taken into account and diagnosis made after considering overlapping symptoms, including symptoms of AIDS-related infections, other illnesses, side effects of medications, and symptoms of distress. For example, symptoms often associated with anxiety or depression, such as problems concentrating and making decisions, difficulties in social or occupational functioning, negative changes in physical appearance, fatigue and sleep disturbances, loss of appetite, declining sexual interest, and weight loss, can be associated with HIV disease, especially if the neurological system has been impacted by the disease.

Employment Issues. Persons with HIV often are faced with difficult employment decisions. Many rely on their employment for their health

insurance. Often, they feel too ill to work and choose to go on disability. This option may offer them time to boost their immune system, but conversely, it also is recognition that HIV has gained control of their lives, which is especially difficult for those strongly tied to their careers. Moreover, with the success of new drug treatments, many who feel ready to return to work fear losing their disability benefits.

Stage 4: End-of-Life Issues

During this stage, clients are interested in talking about end-of-life concerns. These may include making decisions regarding final medical treatment, estate planning and wills, dealing with unresolved relationships and saying goodbye, making video/audiotapes or journals, discussing spiritual questions, planning for their funeral, and making rational suicide plans.

Clients may or may not be ill when they desire to process these issues. The counselor needs to be able to tolerate his or her own anxiety about death and dying and monitor personal beliefs and values around end-of-life decisions. This can be particularly salient while dealing with the issue of rational suicide, the decision to rationally end one's life to avoid the protracted pain, dependence, and economic decline associated with advanced HIV disease (Werth, 1996). As there has been debate surrounding the role of mental health practitioners around hastened death requests, counselors are encouraged to be familiar with the professional literature regarding this controversial area (Silverman, 2000; Rogers & Britton, 1994; Werth, 1992; Werth & Holdwick, 2000).

AIDS Dementia. HIV brain infection and AIDS-related opportunistic infections of the central nervous system are some of the most feared health problems for persons with HIV disease. Significant deterioration in cognitive abilities can occur prior to systemic illness; however, these neurological deficits most often coexist with other opportunistic infections. Unfortunately, the protease inhibitors are not successful in slowing neurological impairment, and thus there are more cases of AIDS dementia surfacing in otherwise healthy individuals. Counseling can be a forum for clients to process their fears and learn adaptive techniques when faced with early symptoms. With the onset of late-stage dementia, more complicated caregiving issues surface, and family and friends frequently need assistance in dealing with their feelings and making appropriate caretaking plans.

Multiple Bereavement. Given that HIV is principally spread through sexual behavior and needle sharing, people with HIV infection often experience multiple losses because of the prevalence of HIV in their social networks (Neugebauer et al., 1992). As a result, people may experience bereavement overload, a syndrome that occurs when a person has not completed the process of mourning the loss of one person when another dies. The pervasive, unrelenting feelings of sorrow, loss, and abandonment can be overwhelming.

SUMMARY

Although this model was presented as linear, a spiral more accurately reflects it. Due to the frequent and many losses and crises associated with HIV, persons will frequently return to earlier stages of adjustment (e.g., after a recent death of someone with AIDS, during acute relational conflicts, when symptoms begin or change, around appointments with physicians, or after episodes of discrimination). The process of adjustment and adaptation is ongoing and frequently laborious.

In counseling persons with HIV disease, counselors need to be cognizant of many unique and challenging issues, as well as display sensitivity to multicultural issues. It also requires a monitoring and management of the counselor's own reaction to the often difficult issues. Using a developmental model can guide counselors in choosing effective and appropriate interventions.

References

Britton, P.J. (2000). Staying on the roller coaster with clients: Implications of the new HIV/AIDS

medical treatments for counseling. *Journal of Mental Health Counseling, 22,* 85–94.

Centers for Disease Control and Prevention. (1999). *HIV/AIDS surveillance report, 11*(no. 2).

Marzuk, P.M., Tardiff, K., Leon, A., Hirsch, C., Hartwell, N., Portera, L., & Iqbal, M. (1997). HIV seroprevalence among suicide victims in New York City, 1991–1993. *American Journal of Psychiatry, 154,* 1720–1725.

Neugebauer, R., Rabkin, J., Williams, J., Remien, R., Goetz, R., & Gorman, J. (1992). Bereavement reactions among homosexual men experiencing multiple losses in the AIDS epidemic. *American Journal of Psychiatry, 149,* 1374–1379.

Nichols, S.E. (1985). Psychosocial reactions of persons with the acquired immunodeficiency syndrome. *Annals of Internal Medicine, 103,* 765–767.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change. *American Psychologist, 47,* 1102–1114.

Rogers, J., & Britton, P. (1994). AIDS and rational suicide: A counseling psychology perspective or a slide on the slippery slope. *The Counseling Psychologist, 22,* 171–178.

Silverman, M.M. (2000). Rational suicide, hastened death, and self-destructive behaviors. *The Counseling Psychologist, 28,* 540–550.

Werth, J.L., Jr. (1992). Rational suicide and AIDS: Considerations for the psychologist. *The Counseling Psychologist, 20,* 645–659.

Werth, J.L., Jr. (1996). *Rational suicide? Implications for mental health professionals.* Bristol, PA: Taylor & Francis.

Werth, J.L., Jr., & Holdwick, D.J., Jr. (2000). A primer on rational suicide and other forms of hastened death. *The Counseling Psychologist, 28,* 511–539.

Winiarski, M.G. (1997). *HIV mental health for the 21st century.* New York: New York University Press.

Suggested Reading

Hoffman, M.A. (1996). *Counseling clients with HIV disease: Assessment, intervention, and prevention.* New York: Guilford Press.

Kain, C.D. (1996). *Positive: HIV affirmative counseling.* Alexandria, VA: American Counseling Association.

Kalichman, S.C. (1998). *Understanding AIDS: Advances in research and treatment* (2nd ed.). Washington, DC: American Psychological Association.

Kelly, J.A. (1995). *Changing HIV risk behavior: Practical strategies.* New York: Guilford Press.

Odets, W., & Shernoff, M. (1994). *The second decade of AIDS: A mental health practice handbook.* New York: Haterleigh Press.

Rabkin, J., Remiem, R., & Wilson, C. (1994). *Good doctors, good patients: Partners in HIV treatment.* New York: NCM.